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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

### **Insurance Division[191]**

Replace Analysis

Replace Reserved Chapter 79 with Chapter 79

### **Education Department[281]**

Replace Chapter 61

### **College Student Aid Commission[283]**

Replace Analysis

Remove Reserved Chapter 26 and Chapter 27

Insert Reserved Chapters 26 and 27

### **Human Services Department[441]**

Replace Analysis

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Replace Reserved Chapters 67 to 73 with Reserved Chapters 67 to 72

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Replace Analysis  
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**Public Safety Department[661]**

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Replace Reserved Chapters 84 to 87 with Reserved Chapters 84 to 86  
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**Transportation Department[761]**

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**Labor Services Division[875]**

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**INSURANCE DIVISION[191]**

[Prior to 10/22/86, see Insurance Department[510], renamed Insurance Division[191] under the “umbrella” of Department of Commerce by the 1986 Iowa Acts, Senate File 2175]

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CHAPTER 79  
PRIOR AUTHORIZATION—PRESCRIPTION DRUG BENEFITS

**191—79.1(505) Purpose.** These rules implement Iowa Code section 505.26 as amended by 2015 Iowa Acts, House File 632, section 9, which requires the commissioner to adopt rules to provide for a single prior authorization form and prior authorization process for approval of prescription drug benefits by health carriers and pharmacy benefits managers.

[ARC 2348C, IAB 1/6/16, effective 2/10/16]

**191—79.2(505) Definitions.** For purposes of this chapter, the definitions found in Iowa Code section 505.26 as amended by 2015 Iowa Acts, House File 632, section 9, shall apply. In addition, the following definitions shall apply:

“*Commissioner*” means the Iowa insurance commissioner.

“*Division*” means the Iowa insurance division.

“*Exigent*” means circumstances as defined under federal regulations relating to the Affordable Care Act, as provided in 45 CFR 156.122.

“*Prescription drug prior authorization*” means requests for preapproval from a payor for specified medications or quantities of medications.

“*Qualified health plan*” or “*QHP*” means a health insurance plan under the Affordable Care Act, which is certified by the health insurance marketplace.

“*Urgent*” means any claim for medical care or treatment to which the application of time periods that either could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the opinion of the physician or health care professional, as defined in Iowa Code chapter 514J, with knowledge of the patient’s medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

[ARC 2348C, IAB 1/6/16, effective 2/10/16]

**191—79.3(505) Prior authorization protocols.** All health carriers, health benefit plans and pharmacy benefits managers must accept the approved prior authorization form from health care providers.

**79.3(1) Duration of approved prior authorization request.** Health carriers, health benefit plans, and pharmacy benefits managers shall provide that approval of a prior authorization request shall be valid for a minimum of 12 months or for a duration that is clinically appropriate for the condition being treated, in accordance with the rules adopted pursuant to Iowa Code section 505.26 as amended by 2015 Iowa Acts, House File 632, section 9. Updates on disease progression must be provided with each renewal request.

**79.3(2) Posting of prior authorization form.** The approved prior authorization form shall be made available electronically on the Web site of the division and on the Web site of each health carrier, health benefit plan or pharmacy benefits manager that uses the form. Health carriers, health benefit plans and pharmacy benefits managers shall allow health care providers to submit a prior authorization request electronically.

**79.3(3) Assignment of identification number.** The health carrier, health benefit plan or pharmacy benefits manager shall assign to each prior authorization request a unique electronic identification number that a provider may use during the prior authorization process to track the request electronically, through a call center, or by fax. This unique identifier may include a format that consists of a patient’s first name, last name and date of birth.

**79.3(4) Posting of required information.** Health carriers, health benefit plans, and pharmacy benefits managers shall make the following available and accessible on their Internet sites:

*a.* Prior authorization requirements and restrictions, including a list of drugs that require prior authorization.

*b.* Clinical criteria that are easily understandable to health care providers, including clinical criteria for reauthorization of a previously approved drug after the prior authorization period has expired.

*c.* Standards for submitting and considering requests, including evidence-based guidelines, when possible, for making prior authorization determinations.

d. Health carriers shall provide a process for health care providers to appeal a prior authorization determination as provided in Iowa Code chapter 514J. Pharmacy benefits managers shall provide a process for health care providers to appeal a prior authorization determination that is consistent with the process provided in Iowa Code chapter 514J. Appeal standards as provided in Iowa Code chapter 514J are set out in Appendix A herein.

**79.3(5) Urgent claims.** Prior authorization requests for urgent claims shall be approved or denied as soon as possible, but in no case later than 72 hours after receipt of the request.

**79.3(6) Nonurgent claims.** Prior authorization requests for nonurgent claims shall be approved or denied as soon as possible, but in no case later than five calendar days after receipt of the request.

**79.3(7) Incomplete or additional information.** If a request for a prescription drug prior authorization is incomplete or additional information is required, the health carrier, health benefit plan, or pharmacy benefits manager may request additional information within the applicable time periods provided in this rule. Once the additional information is submitted, the applicable time period for approval or denial shall begin again.

**79.3(8) Prescription drug benefits provided by a qualified health plan.** A QHP shall have procedures in place that comply with the health insurance issuer standards related to expedited review based on exigent circumstances and coverage determinations no later than 24 hours after receipt of requests as provided for in 45 CFR 156.122(c).

**79.3(9) Prior authorization granted.** If a health carrier, health benefit plan or pharmacy benefits manager does not approve or deny a completed prior authorization request or request additional information from a health care provider within the time limits set forth in this rule, the prior authorization request shall be deemed to have been granted.

**79.3(10) Denial of prior authorization request.** In the case of a denial of a prior authorization request, the health carrier, health benefit plan or pharmacy benefits manager shall provide the reason for the denial, information regarding the denial and, if formulary alternatives are available, direction on how to contact the health carrier or health benefit plan.

[ARC 2348C, IAB 1/6/16, effective 2/10/16]

#### **191—79.4(505) Filing with the division.**

**79.4(1)** A prior authorization form approved by the commissioner shall meet all of the following requirements:

a. Not exceed two pages in length, except that a prior authorization form may exceed that length as determined to be appropriate by the commissioner. Exceptions to the two-page limit shall consider clinical differences and complexity of the requested prescription drugs.

b. Be available in electronic format.

c. Be transmissible in an electronic format or a fax transmission.

**79.4(2)** The prior authorization form utilized by health carriers, health benefit plans, and pharmacy benefits managers shall first be examined and approved by the commissioner. Health carriers shall submit the form electronically using the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Pharmacy benefits managers shall submit the form in writing to the commissioner by regular mail, fax or electronic means. Nothing in this rule shall preclude the use of standards by health carriers and pharmacy benefits managers in accordance with NCPDP SCRIPT.

**79.4(3)** The form submitted for approval shall consider any prior authorization forms developed by the federal Centers for Medicare and Medicaid Services or the U.S. Department of Health and Human Services and any national standards pertaining to electronic prior authorization for prescription drugs, including ASC X12 278 standard transactions and NCPDP SCRIPT Standard ePA transactions.

[ARC 2348C, IAB 1/6/16, effective 2/10/16]

**191—79.5(505) Violations.** A health carrier, health benefit plan or pharmacy benefits manager found after hearing to have violated a provision of this chapter shall be subject to the penalties set forth in Iowa Code chapter 505.

[ARC 2348C, IAB 1/6/16, effective 2/10/16]

**191—79.6(505) Applicability.** This chapter shall not apply to Medicare or Medicaid.

[ARC 2348C, IAB 1/6/16, effective 2/10/16]

These rules are intended to implement Iowa Code section 505.26 as amended by 2015 Iowa Acts, House File 632, section 9.

[Filed ARC 2348C (Notice ARC 2228C, IAB 10/28/15), IAB 1/6/16, effective 2/10/16]

APPENDIX A  
**Standards Related to Appeals**  
**(as provided in Iowa Code chapter 514J)**

**514J.107 External review — standard.**

1. A covered person or the covered person's authorized representative may file a written request for an external review with the commissioner within four months after any of the following events:

- a.* The date of receipt of a final adverse determination.
- b.* The failure of a health carrier to issue a written decision within thirty days following the date the covered person or the covered person's authorized representative filed a grievance involving an adverse determination as provided in section 514J.106, subsection 2.
- c.* The agreement of the health carrier to waive the requirement that the covered person or the covered person's authorized representative exhaust the health carrier's internal grievance procedures before filing a request for external review of an adverse determination as provided in section 514J.106, subsection 4.

2. Within one business day after the date of receipt of a request for external review, the commissioner shall send a copy of the request to the health carrier.

3. Within five business days following the date of receipt of the external review request from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

- a.* The individual is or was a covered person under the health benefit plan at the time the health care service was recommended or requested.
- b.* The health care service that is the subject of the adverse determination or of the final adverse determination, is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.
- c.* The covered person or the covered person's authorized representative has exhausted the health carrier's internal grievance process, unless the covered person or the covered person's authorized representative is not required to exhaust the health carrier's internal grievance process pursuant to section 514J.106 or this section.

*d.* The covered person or the covered person's authorized representative has provided all the information and forms required to process an external review request.

4. Within one business day after completion of a preliminary review pursuant to subsection 3, the health carrier shall notify the commissioner and the covered person or the covered person's authorized representative in writing whether the request is complete and whether the request is eligible for external review.

*a.* If the health carrier determines that the request is not complete, the health carrier shall notify the covered person or the covered person's authorized representative and the commissioner in writing that the request is not complete and what information or materials are needed to make the request complete.

*b.* If the health carrier determines that the request is not eligible for external review, the health carrier shall issue a notice of initial determination in writing informing the covered person or the covered person's authorized representative and the commissioner of that determination and the reasons the request is not eligible for review. The health carrier shall also include a statement in the notice informing the covered person or the covered person's authorized representative that the health carrier's initial determination of ineligibility may be appealed to the commissioner.

5. The commissioner may specify by rule the form required for the health carrier's notice of initial determination and any supporting information to be included in the notice.

6. The commissioner may determine that a request is eligible for external review, notwithstanding a health carrier's initial determination that the request is not eligible, and refer the request for external review. In making this determination, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

7. Within one business day after receipt of notice from a health carrier that a request for external review is eligible for external review or upon a determination by the commissioner that a request is eligible for external review, the commissioner shall do all of the following:

*a.* Assign an independent review organization from the list of approved independent review organizations maintained by the commissioner and notify the health carrier of the name of the assigned independent review organization. The assignment of an independent review organization shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns.

*b.* Notify the covered person or the covered person's authorized representative in writing that the request is eligible and has been accepted for external review including the name of the assigned independent review organization and that the covered person or the covered person's authorized representative may submit in writing to the independent review organization within five business days following receipt of such notice from the commissioner, additional information that the independent review organization shall consider when conducting the external review. The independent review organization may, in the organization's discretion, accept and consider additional information submitted by the covered person or the covered person's authorized representative after five business days.

8. Within five business days after receipt of notice from the commissioner pursuant to subsection 7, the health carrier shall provide to the independent review organization the documents and any information considered in making the adverse determination or final adverse determination. Failure by the health carrier to provide the documents and information within the time specified shall not delay the conduct of the external review.

9. If the health carrier fails to provide the documents and information within the time specified, the independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Within one business day after making such a decision, the independent review organization shall notify the covered person or the covered person's authorized representative, the health carrier, and the commissioner of its decision.

10. The independent review organization shall review all of the information and documents received pursuant to subsection 8 and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subsection 7, paragraph "b". Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall, within one business day, forward the information to the health carrier. In reaching a decision the independent review organization is not bound by any decisions or conclusions reached during the health carrier's internal grievance process.

11. Upon receipt of information forwarded pursuant to subsection 10, a health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

*a.* Reconsideration by the health carrier of its determination shall not delay or terminate the external review. The external review shall only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

*b.* Within one business day after making a decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person or the covered person's authorized representative, the independent review organization, and the commissioner in writing of its decision. The independent review organization shall terminate the external review upon receipt of notice of the health carrier's decision to reverse its adverse determination or final adverse determination.

12. In addition to the documents and information provided to the independent review organization pursuant to this section, the independent review organization shall, to the extent the information or documents are available and the independent review organization considers them appropriate, consider the following in reaching a decision:

*a.* The covered person's pertinent medical records.

- b.* The treating health care professional's recommendation.
- c.* Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, or the covered person's treating physician or other health care professional.
- d.* The terms of coverage under the covered person's health benefit plan with the health carrier, to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.
- e.* The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations.
- f.* Any applicable clinical review criteria developed and used by the health carrier.
- g.* The opinion of the independent review organization's clinical reviewer after considering the information or documents described in paragraphs "a" through "f" to the extent the information or documents are available and the clinical reviewer considers them relevant.

13. *a.* Within forty-five days after the date of receipt of a request for an external review, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or final adverse determination of the health carrier to the covered person or the covered person's authorized representative, the health carrier, and the commissioner.

*b.* The independent review organization shall include in its decision all of the following:

- (1) A general description of the reason for the request for external review.
- (2) The date the independent review organization received the assignment from the commissioner to conduct the external review.
- (3) The date the external review was conducted.
- (4) The date of the decision.
- (5) The principal reason or reasons for its decision, including what applicable evidence-based standards, if any, were a basis for its decision.
- (6) The rationale for its decision.
- (7) References to evidence or documentation, including evidence-based standards, considered in reaching its decision.

14. Upon receipt of notice of a decision reversing the adverse determination or final adverse determination of the health carrier, the health carrier shall immediately approve the coverage that was the subject of the determination.

#### **514J.108 External review — expedited.**

1. Notwithstanding section 514J.107, a covered person or the covered person's authorized representative may make an oral or written request to the commissioner for an expedited external review at the time the covered person or the covered person's authorized representative receives any of the following:

*a.* An adverse determination that involves a medical condition of the covered person for which the time frame for completion of an internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

*b.* A final adverse determination that involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

*c.* A final adverse determination that concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, and the covered person has not been discharged from a facility.

2. *a.* Upon receipt of a request for an expedited external review, the commissioner shall immediately send written notice of the request to the health carrier.

*b.* Immediately upon receipt of notice of a request for expedited external review, the health carrier shall complete a preliminary review of the request to determine whether the request meets the eligibility requirements for external review set forth in section 514J.107, subsection 3, and this section.

*c.* The health carrier shall then immediately issue a notice of initial determination informing the commissioner and the covered person or the covered person's authorized representative of its eligibility determination including a statement informing the covered person or the covered person's authorized representative of the right to appeal that determination to the commissioner.

*d.* The commissioner may specify by rule the form required for the health carrier's notice of initial determination and any supporting information to be included in the notice.

3. The commissioner may determine that a request is eligible for expedited external review, notwithstanding a health carrier's initial determination that the request is not eligible. In making a determination, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter. The commissioner shall make a determination pursuant to this subsection as expeditiously as possible.

4. *a.* Upon receipt of notice from a health carrier that a request is eligible for expedited external review or upon a determination by the commissioner that a request is eligible for expedited external review, the commissioner shall immediately assign an independent review organization from the list of approved independent review organizations maintained by the commissioner to conduct the expedited external review. The commissioner shall then immediately notify the health carrier and the covered person or the covered person's authorized representative of the name of the assigned independent review organization.

*b.* The assignment of an independent review organization shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns.

5. Upon receiving notice of the independent review organization assigned to conduct the expedited external review, the health carrier shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the independent review organization electronically or by telephone or facsimile or any other available expeditious method.

6. The independent review organization is not bound by any decisions or conclusions reached during the health carrier's internal grievance process. The independent review organization shall consider the documents and information provided by the health carrier, and to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

*a.* The covered person's pertinent medical records.

*b.* The treating health care professional's recommendation.

*c.* Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's authorized representative, or the covered person's treating physician or other health care professional.

*d.* The terms of coverage under the covered person's health benefit plan with the health carrier, to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

*e.* The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations.

*f.* Any applicable clinical review criteria developed and used by the health carrier.

*g.* The opinion of the independent review organization's clinical reviewer after considering the information or documents described in paragraphs "a" through "f" to the extent the information or documents are available and the clinical reviewer considers them relevant.

7. *a.* As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two hours after the date of receipt of an eligible request for expedited external review, the assigned independent review organization shall do all of the following:

(1) Make a decision to uphold or reverse the adverse determination or final adverse determination of the health carrier.

(2) Notify the covered person or the covered person's authorized representative, the health carrier, and the commissioner of its decision.

*b.* If the notice given by the independent review organization pursuant to paragraph "a" was not in writing, within forty-eight hours after providing that notice, the independent review organization shall provide written confirmation of the decision to the covered person or the covered person's authorized representative, the health carrier, and the commissioner that includes the information set forth in section 514J.107, subsection 13, paragraph "b".

*c.* Upon receipt of the notice of decision by an independent review organization pursuant to paragraph "a" reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

CHAPTER 61  
IOWA READING RESEARCH CENTER

**281—61.1(256) Establishment.** There is established an Iowa reading research center. The director of the department of education shall select a public education entity to serve as the host for the Iowa reading research center. Preference shall be given to a school district, an area education agency, or the joint area education agencies system. The selection of a host shall be for a specified period of time.

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

**281—61.2(256) Purpose.** The purpose of the center shall be to apply current research on literacy to provide for the development and dissemination of all of the following, although each of the following will not necessarily be of equal priority or immediacy:

1. Instructional strategies for prekindergarten through grade 12 to achieve literacy proficiency that includes reading, reading comprehension, and writing for all students.
2. Strategies for identifying and providing evidence-based interventions for students, beginning in kindergarten, who are at risk of not achieving literacy proficiency.
3. Models for effective school, parent, and community partnerships to improve student literacy.
4. Reading assessments.
5. Professional development strategies and materials to support teacher effectiveness in student literacy development.
6. Data reports on attendance center, school district, and statewide progress toward literacy proficiency in the context of student, attendance center, and school district demographic characteristics.
7. An intensive summer literacy program, referred to in rule 281—61.3(256).

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

**281—61.3(256) Intensive summer literacy program.** The center shall establish program criteria and guidelines for implementation of the program by school districts, under rules adopted by the state board of education.

**61.3(1) Program criteria.** Each district's intensive summer literacy program shall be implemented consistent with 281—Chapter 62 and shall meet the following program criteria.

*a. Criterion 1.* Each district shall adopt instructional practices or programs that have demonstrated success and that include explicit and systematic instruction in foundational reading skills based on student need. Those instructional practices or programs shall incorporate the requirements of Iowa Code section 279.68, subsection 2, paragraph "d," subparagraph (3), subparagraph division (a). To meet this criterion, each district must:

- (1) Adopt an instructional program from the department's review of evidence-based early literacy interventions, or
- (2) Adopt instructional practices or programs that have been empirically shown to increase student literacy achievement.

*b. Criterion 2.* Each district shall employ skilled, high-quality instructors or provide instructors with required training, or do both. To meet this criterion, a district must hire instructors whose qualifications and training meet the requirements of the evidence-based intervention chosen. In the absence of specifications from the intervention chosen, a district must hire instructors who, at a minimum, hold a current Iowa teaching license with an endorsement in elementary education or in reading (K-8) or as a reading specialist. For the purposes of paragraph 61.3(1) "b," a district may "hire" or "employ" personnel directly, through an agreement with one or more other districts, through an agreement with one or more accredited nonpublic schools, through an agreement with one or more state agencies or governmental subdivisions, through an agreement with one or more private not-for-profit community agencies, or some combination thereof.

*c. Criterion 3.* Each district shall allow sufficient time for intensive reading instruction and student learning. To meet this criterion, a district must implement, at a minimum, the total number of hours of instructional time described by the evidenced-based intervention chosen. In the absence of

specifications from the intervention chosen, a district must provide a minimum of 70 hours of intensive reading instruction.

*d. Criterion 4.* Each district shall provide intensive instruction in small classes and small groups. To meet this criterion, a district must employ the same instructional grouping formats described in the evidence-based intervention chosen. In the absence of specifications from the intervention chosen, a district must ensure that it delivers whole-class instruction in class sizes of 15 or fewer students and that it delivers targeted intervention based on student need in small groups of 5 or fewer students. A district may elect to provide class and group sizes smaller than specified in this criterion.

*e. Criterion 5.* Each district shall monitor and promote student attendance. To meet this criterion, each district must adhere to an attendance policy that requires 85 percent attendance by each student.

*f. Criterion 6.* Each district shall evaluate student outcomes and program implementation. Evaluation of student outcomes includes attendance data and student achievement data. On a weekly basis, each district shall use the department-approved literacy assessment used during the school year to evaluate student progress toward end-of-third-grade proficiency. Evaluation of program implementation shall align with the district's plan to address reading proficiency in its comprehensive school improvement plan, as required by rule 281—62.9(256,279). Program evaluation shall also include a measure of fidelity in implementing, at a minimum, the following requirements: instructor qualifications, amount of instructional time, group size, attendance data, and progress-monitoring data.

*g. Criterion 7.* Each district shall identify whether each student successfully completes the program. Each student who successfully completes the program is eligible for promotion to grade four. Each district shall provide to the parents or legal guardians of each student written notice about whether the student successfully completed the program. The notice shall include information about attendance, academic performance, additional or continuing areas of need and whether the child is eligible for promotion. Successful completion shall be defined as meeting either of the following standards:

(1) Consistent attainment of an end-of-third-grade proficiency standard pursuant to paragraph 61.3(1) "f," or

(2) Attendance at no less than 85 percent of the program's sessions.

*h. Criterion 8.* Each program shall be under the leadership and supervision of at least one teacher, as described in paragraph 61.3(1) "b," and at least one appropriately licensed administrator. The two roles may be filled by the same individual. Either the teacher or the administrator shall hold a reading (K-8) endorsement or a reading specialist endorsement. Leadership and supervision under paragraph 61.3(1) "h" shall include monitoring the program for compliance with the program criteria in subrule 61.3(1).

*i. Option to use private providers.* A district may enter into an agreement with a private provider to provide intensive summer literacy instruction required by this chapter and 281—Chapter 62, at the election of a parent and in lieu of programming provided by the district. Any election under this paragraph shall be at the parent's sole cost. The private provider shall use evidence-based instructional strategies. If a child successfully completes a private program, as defined in paragraph 61.3(1) "g," the child shall be eligible for promotion to fourth grade.

**61.3(2) Guidelines for implementation by school districts.** The center shall periodically publish guidelines to assist school districts in applying the program criteria contained in subrule 61.3(1) and in improving the performance of intensive summer literacy programs. The center shall make such guidelines available on its Web site.

[ARC 0475C, IAB 11/28/12, effective 1/2/13; ARC 2343C, IAB 1/6/16, effective 2/10/16]

**281—61.4(256) First efforts of the center.** The first efforts of the center shall focus on improving reading performance and instruction in kindergarten through grade 3.

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

**281—61.5(256) Nature of the center's operation.** The center shall govern its work according to the following requirements.

**61.5(1) *Use of expertise.*** The center shall draw upon national and state expertise in the field of literacy proficiency, including experts from Iowa's institutions of higher education and area education agencies with backgrounds in literacy development.

**61.5(2) *Data and report development.*** The center and its director shall seek support from the Iowa research community in methodologies for the collection of student literacy data and in data report development, the analysis of available information from Iowa education data sources, and the analysis of progress toward literacy proficiency.

**61.5(3) *Coordination with the department.*** The center and its director shall work with the department of education to identify additional needs for tools and technical assistance for Iowa schools to help schools achieve literacy proficiency goals and seek public and private partnerships in developing and accessing necessary tools and technical assistance.

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

**281—61.6(256) Nature of the center's products.** The center's strategies, models, materials, and assessments, including the products referred to in subrule 61.6(3), shall be judged by and subject to the following requirements:

**61.6(1) *Research-based.*** To the extent possible, strategies, models, materials, and assessments shall be research-based.

**61.6(2) *Replicable.*** The strategies, models, materials, and assessments produced by the center shall contain evidence establishing that they are replicable by Iowa school districts, area education agencies, and accredited nonpublic schools.

**61.6(3) *Sustainable.*** The strategies, models, and materials produced by the center shall contain evidence establishing that they are capable of sustainable implementation.

**61.6(4) *Publicly available.*** Due to the nature of the center, its products shall be widely and liberally distributed and used.

*a.* Regardless of any intellectual property right that may accrue to the center, the department of education shall have a perpetual, irrevocable, royalty-free, nonexclusive, nontransferable license to use any of the strategies, models, and materials produced by the center.

*b.* Regardless of any intellectual property right that may accrue to the center, each school district, area education agency, and accredited nonpublic school shall have a perpetual, irrevocable, royalty-free, nonexclusive, nontransferable license to use any of the strategies, models, and materials produced by the center.

*c.* Regardless of any intellectual property right that may accrue to the center, each school district, area education agency, accredited nonpublic school, and practitioner preparation program approved by the department of education shall have a perpetual, irrevocable, royalty-free, nonexclusive, nontransferable license to use any of the strategies, models, and materials produced by the center to provide training to current and prospective teachers and administrators.

*d.* Notwithstanding paragraphs 61.6(4) "a" through "c," the center may seek reimbursement from a school district, area education agency, accredited nonpublic school, or practitioner preparation program approved by the department of education for the actual cost of delivering the center's products. For purposes of this paragraph, actual costs may include printing, telecommunications expenses, personnel time, postage, and other costs, but shall not include any amount that represents a royalty or other compensation for the use of the center's intellectual property.

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

**281—61.7(256) Governance and leadership of the center.** The center shall be governed in the following manner.

**61.7(1) *Director and other personnel.*** The center shall have a director who shall be an employee of the host referred to in rule 281—61.1(256). The director of the department of education or the director's designee, in consultation with the host and the advisory council, shall select, determine the compensation of, and annually evaluate the director of the center.

*a.* Responsibilities of the director of the center will include the following:

(1) Enacting the priorities of the reading research center, as defined by the department;

- (2) Achieving the Iowa reading research center's mission and purpose;
  - (3) Directing the center's budget;
  - (4) Managing the center's staff;
  - (5) Managing and overseeing the request for proposal (RFP) or contracting process or both to enact priorities of the center;
  - (6) Providing oversight and management of all contracts and projects initiated by the center;
  - (7) Establishing models for an intensive summer literacy program replicable in Iowa schools;
  - (8) Disseminating literacy research and its application; and
  - (9) Submitting required reports to the department and the general assembly.
- b. The center may employ such other personnel as may be necessary to fulfill its responsibilities, upon approval of such positions by the director of the department of education.

**61.7(2) *Advisory council.*** When setting priorities for the center, the department of education shall seek advice and assistance from an advisory council. The advisory council shall establish its bylaws and shall govern itself by the following paragraphs:

a. The advisory council shall consist of representatives of the department, school districts, area education agencies, accredited nonpublic schools, institutions of higher education, organizations representing reading and literacy teachers, community-based nonprofit organizations that are focused on literacy, statewide literacy organizations, and parents. Members who offer other perspectives may be appointed. Members may serve in more than one role. Members shall be appointed by the director of the department of education or the director's designee. Actual expenses for members of the advisory council may be assumed by the reading research center.

b. The advisory council shall recommend and continually review center priorities, which shall be consistent with these rules. The advisory council shall annually submit to the department a recommended set of projects and priorities for the reading research center.

c. The advisory council shall provide input to the director of the department on the desired qualifications for the position of director of the reading research center.

d. The advisory council shall advise and assist the center in preparing the annual report required by rule 281—61.9(256).

e. The advisory council shall foster collaboration across the Iowa reading research and evaluation community and serve as a facilitator in identifying additional research needs and ways to apply research to practice in Iowa schools and communities.

f. The advisory council shall stay abreast of emerging trends, research, and effective literacy practices.

g. The advisory council shall assist the director of the center in reviewing proposals for quality, viability, and statewide impact.

h. Meetings of the advisory council are public meetings subject to statutory open meetings requirements.

**61.7(3) *Use of advisory council recommendations.*** The department shall consider the priorities established by its advisory council in determining which projects or activities to direct the center to enact, consistent with these rules and with the center's funding.

**61.7(4) *Contracts and awards.*** In the furtherance of its work, the center may contract with other entities or may make awards by competitive bid. The rules in this chapter shall be a term of any contract or award under this subrule. Any product produced pursuant to a contract or award shall be subject to these rules, including subrule 61.6(4).

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

**281—61.8(256) *Financing of the center.*** The center will be financed in the following manner:

**61.8(1) *Host as fiscal agent.*** The host shall be the fiscal agent for the center.

**61.8(2) *Public or private funds.*** The host and the center may solicit and accept funds from public and private sources for the fulfillment of the mission and purpose of the center.

**61.8(3) Oversight by the department.** The department shall have oversight responsibilities for the financial operations of the center.

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

**281—61.9(256) Annual report.** The center shall submit a report of its activities to the general assembly by January 15 annually.

[ARC 0475C, IAB 11/28/12, effective 1/2/13]

These rules are intended to implement Iowa Code sections 256.7(31) and 256.9(53) “c.”

[Filed ARC 0475C (Notice ARC 0389C, IAB 10/3/12), IAB 11/28/12, effective 1/2/13]

[Filed ARC 2343C (Notice ARC 2186C, IAB 10/14/15), IAB 1/6/16, effective 2/10/16]



**COLLEGE STUDENT AID COMMISSION[283]**

[Prior to 8/10/88, see College Aid Commission[245]]

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**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  
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PREAMBLE

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

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

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

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

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

**36.2(3)** ICFs/ID shall pay the monthly amount due to the department.

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

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

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

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

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

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

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

**441—36.5** Reserved.

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

DIVISION II  
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

PREAMBLE

These rules describe the nursing facility quality assurance assessment authorized by Iowa Code chapter 249L. The rules explain how the assessment is determined and paid.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

**441—36.6(249L) Assessment.**

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

- a. Nursing facilities operated by the state.
- b. Non-state government-owned or government-operated nursing facilities.
- c. Distinct-part skilled nursing units and swing-bed units operated by a hospital.

**36.6(2) Assessment level.** Effective July 1, 2012, the assessment level for each nursing facility shall be determined on an annual basis and shall be effective for the state fiscal year.

a. Effective July 1, 2011, nursing facilities with 46 or fewer licensed beds are required to pay a quality assurance assessment of \$1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the number of licensed beds on file with the department of inspections and appeals as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

b. Nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the Iowa department of commerce are required to pay a quality assurance assessment of \$1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, continuing care retirement center designations as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

c. Nursing facilities with annual Iowa Medicaid patient days of 26,500 or more are required to pay a quality assurance assessment of \$1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the annual number of Iowa Medicaid patient days reported in the most current cost report submitted to the Iowa Medicaid enterprise as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

d. All other nursing facilities are required to pay a quality assurance assessment of \$5.26 per non-Medicare patient day.

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

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

- a. Use Form 470-4836, Nursing Facility Quality Assurance Assessment Calculation Worksheet, to calculate the quarterly assessment amount due.
- b. Submit Form 470-4836 and the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

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

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

**36.7(4)** A nursing facility that fails to pay the quality assurance assessment within the time frame specified above shall pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue.

*a.* If the facility substantiates good cause beyond the facility's control for failure to comply with payment of the quality assurance assessment, the department shall waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

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

**36.7(5)** For facilities certified to participate in the Medicaid program, the department shall deduct the quarterly amount due from Medicaid payments to the facility if the department has not received the quality assurance assessment amount due by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

**441—36.8 and 36.9** Reserved.

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

DIVISION III  
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

PREAMBLE

These rules describe the hospital health care access assessment authorized by Iowa Code chapter 249M. The rules explain how the assessment is determined and paid.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

**441—36.10(249M) Application of assessment.**

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

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

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

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**441—36.11(249M) Determination and payment of assessment.** The assessment shall be determined and paid as follows:

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

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

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

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

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

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

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

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

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

**441—36.12(249M) Termination of health care access assessment.** If the federal government fully funds Iowa's medical assistance program, if federal law changes to negatively impact the assessment program as determined by the department, or if a federal audit determines the assessment program is invalid, the assessment shall terminate on the date the federal statutory, regulatory, or interpretive change takes effect.

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CHAPTER 52  
PAYMENT

[Prior to 7/1/83, Social Services[770] Ch 52]  
[Prior to 2/11/87, Human Services[498]]

**441—52.1(249) Assistance standards.** Assistance standards are the amounts of money allowed on a monthly basis to recipients of state supplementary assistance in determining financial need and the amount of assistance granted.

**52.1(1) Protective living arrangement.** The following assistance standards have been established for state supplementary assistance for persons living in a family-life home certified under rules in 441—Chapter 111.

\$792	Care allowance
<u>\$103</u>	Personal allowance
\$895	Total

**52.1(2) Dependent relative.** The following assistance standards have been established for state supplementary assistance for dependent relatives residing in a recipient’s home.

- a. Aged or disabled client and a dependent relative . . . . . \$1,110
- b. Aged or disabled client, eligible spouse, and a dependent relative . . . . . \$1,477
- c. Blind client and a dependent relative . . . . . \$1,132
- d. Blind client, aged or disabled spouse, and a dependent relative . . . . . \$1,499
- e. Blind client, blind spouse, and a dependent relative . . . . . \$1,521

**52.1(3) Residential care.** Payment to a recipient in a residential care facility shall be made on a flat per diem rate of \$17.86 or on a cost-related reimbursement system with a maximum per diem rate of \$30.05. The department shall establish a cost-related per diem rate for each facility choosing this method of payment according to rule 441—54.3(249).

The facility shall accept the per diem rate established by the department for state supplementary assistance recipients as payment in full from the recipient and make no additional charges to the recipient.

a. All income of a recipient as described in this subrule after the disregards described in this subrule shall be applied to meet the cost of care before payment is made through the state supplementary assistance program.

Income applied to meet the cost of care shall be the income considered available to the resident pursuant to supplemental security income (SSI) policy plus the SSI benefit less the following monthly disregards applied in the order specified:

- (1) When income is earned, impairment related work expenses, as defined by SSI plus \$65 plus one-half of any remaining earned income.
- (2) An allowance of \$103 to meet personal expenses and Medicaid copayment expenses.
- (3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse’s countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard shall be made.
- (4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent’s countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.
- (5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

(6) The income of recipients of state supplementary assistance or Medicaid needed to pay the cost of care in another residential care facility, a family-life home, an in-home health-related care provider, a home- and community-based waiver setting, or a medical institution is not available to apply to the cost of care. The income of a resident who lived at home in the month of entry shall not be applied to the cost of care except to the extent the income exceeds the SSI benefit for one person or for a married couple if the resident also had a spouse living in the home in the month of entry.

*b.* Payment is made for only the days the recipient is a resident of the facility. Payment shall be made for the date of entry into the facility, but not the date of death or discharge.

*c.* Payment shall be made in the form of a grant to the recipient on a post payment basis.

*d.* Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the recipient shall remain eligible for all other benefits of the program.

*e.* Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 30 days during any calendar year, unless a family member or legal guardian of the resident, the resident's physician, case manager, or department service worker provides signed documentation that additional visitation days are desired by the resident and are for the benefit of the resident. This documentation shall be obtained by the facility for each period of paid absence which exceeds the 30-day annual limit. This information shall be retained in the resident's personal file. If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a Case Activity Report, Form 470-0042, to the county office of the department to terminate the state supplementary assistance payment.

A family member may contribute to the cost of care for a resident subject to supplementation provisions at rule 441—51.2(249) and any contributions shall be reported to the county office of the department by the facility.

*f.* Payment will be made for a period not to exceed 20 days in any calendar month when the resident is absent due to hospitalization. A resident may not start state supplementary assistance on reserve bed days.

*g.* The per diem rate established for recipients of state supplementary assistance shall not exceed the average rate established by the facility for private pay residents.

(1) Residents placed in a facility by another governmental agency are not considered private paying individuals. Payments received by the facility from such an agency shall not be included in determining the average rate for private paying residents.

(2) To compute the facilitywide average rate for private paying residents, the facility shall accumulate total monthly charges for those individuals over a six-month period and divide by the total patient days care provided to this group during the same period of time.

**52.1(4) *Blind.*** The standard for a blind recipient not receiving another type of state supplementary assistance is \$22 per month.

**52.1(5) *In-home, health-related care.*** Payment to a person receiving in-home, health-related care shall be made in accordance with rules in 441—Chapter 177.

**52.1(6) *Minimum income level cases.*** The income level of those persons receiving old age assistance, aid to the blind, and aid to the disabled in December 1973 shall be maintained at the December 1973 level as long as the recipient's circumstances remain unchanged and that income level is above current standards. In determining the continuing eligibility for the minimum income level, the income limits, resource limits, and exclusions which were in effect in October 1972 shall be utilized.

**52.1(7) *Supplement for Medicare and Medicaid eligibles.*** Payment to a person eligible for the supplement for Medicare and Medicaid eligibles shall be \$1 per month.

This rule is intended to implement Iowa Code chapter 249.

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<sup>1</sup> 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.



CHAPTERS 67 to 70  
Reserved

CHAPTER 71  
EMERGENCY FOOD DISTRIBUTION PROGRAM  
Rescinded, effective 11/1/86

CHAPTER 72  
EMERGENCY FOOD AND SHELTER PROGRAM  
Rescinded, effective 11/1/86



TITLE VIII  
MEDICAL ASSISTANCE  
CHAPTER 73  
MANAGED CARE

PREAMBLE

This chapter provides that most Iowa medical assistance program benefits will be provided through managed care. Notwithstanding any provisions of 441—Chapters 74 through 91, program benefits shall be provided through managed care as provided in this chapter. The program benefits provided through managed care will be paid for by managed care organizations participating in the program pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the managed care organization, consistent with this chapter and with the contract between the department and the managed care organization.

Implementation of managed care pursuant to this chapter is subject to approval by the Secretary of the United States Department of Health and Human Services (Secretary) of any Iowa state plan amendments and any waivers of the requirements of Title XIX of the Social Security Act that are required to allow for federal funding.

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements under Title XIX or the terms of the waiver shall prevail.

**441—73.1(249A) Definitions.**

*“Behavioral health services”* means mental health and substance use disorder treatment services.

*“Capitated payment”* means a monthly payment to the contractor on behalf of each enrollee for the provision of health services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

*“Choice counseling”* means the provision of unbiased information on managed care plans or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the managed care organizations or the state, to answer questions about each of the options available, and to facilitate enrollment with a managed care organization.

*“Claim”* means a formal request for payment for benefits received or services rendered.

*“Clean claim”* means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. “Clean claim” does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

*“CMS”* means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

*“Code of Federal Regulations (CFR)”* means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

*“Community-based case management”* means a collaborative process of planning, facilitation, and advocacy for options and services to meet a member’s needs through communication and available resources to promote high-quality, cost-effective outcomes.

*“Contract”* means a contract between the department and a managed care organization. These contracts shall meet all applicable requirements of state and federal law, including the requirements of the Code of Federal Regulations, Title 42 CFR 434 as amended to October 16, 2015.

*“Covered services”* means physical health, behavioral health and long-term care services set forth in rule 441—73.5(249A).

*“Department”* means the Iowa department of human services.

*“Discharge planning”* means the process, which begins at admission, of determining an enrollee’s continued need for treatment services and of developing a plan to address ongoing needs.

*“Emergency medical condition”* means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

*“Emergency services”* means covered inpatient and outpatient services that are both furnished by a provider that is qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition.

*“EMTALA”* means the Emergency Medical Treatment and Active Labor Act.

*“Enrollee”* means a HAWK-I, Iowa Health and Wellness Plan or Medicaid member who is eligible for managed care organization enrollment and has been enrolled with a managed care organization as defined in subrule 73.3(2).

*“Enrollment broker”* means the entity the department uses to enroll persons in a managed care organization. The enrollment broker must be conflict free and meet all applicable requirements of state and federal law, including 42 CFR 438.10 as amended to October 16, 2015.

*“HAWK-I program”* means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

*“Health maintenance organization”* means a public or private organization which is licensed as a managed care organization or prepaid health plan under insurance division rules set forth in 191—Chapter 40.

*“HIP”* means the health insurance premium payment program.

*“Home- and community-based services (HCBS)”* means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

*“Incident reporting”* means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization, or both;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

*“Insolvency”* means a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business or when the liabilities of the entity exceed its assets.

*“Iowa Health and Wellness Plan”* means the medical assistance program set forth in 441—Chapter 74.

*“Level of care”* means an evaluation to determine and establish an individual’s need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future.

*“Long-term care (LTC)”* or *“long-term services and supports (LTSS)”* means the services of a nursing facility (NF), an intermediate care facility for persons with an intellectual disability (ICF/ID), state resource centers or services funded through Section 1915(c) home- and community-based services waivers, Section 1915(i) state plan home- and community-based habilitation program and the PACE program.

“*Managed care organization (MCO)*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

“*Mandatory enrollment*” means mandatory participation in a managed care organization as specified in subrule 73.3(2).

“*Medical loss ratio (MLR)*” means the percentage of capitation payments that is used to pay medical expenses.

“*Medically necessary services*” means those covered services that are, under the terms and conditions of the contract, determined through contractor utilization management to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
2. Provided for the diagnosis or direct care and treatment of the condition of the member to enable the member to make reasonable progress in treatment;
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting;
4. Not primarily for the convenience of the member, the member’s physician or other provider; and
5. The most appropriate level of covered services that can safely be provided.

“*Medical records*” means all medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

“*Member*” means any person determined by the department to be eligible for the HAWK-I program, the Iowa Health and Wellness Plan, or the Medicaid program.

“*Money Follows the Person (MFP) Rebalancing Demonstration Grant*” means a federal grant that will assist Iowa in transitioning individuals from a nursing facility or ICF/ID into the community and in rebalancing long-term care expenditures.

“*Needs-based eligibility*” means an evaluation to determine and establish an individual’s need for habilitation services.

“*Network*” or “*provider network*” means a group of participating health care providers (both individual and group practitioners) linked through contractual arrangements to the contractor to supply a range of health care services.

“*Out-of-network provider*” means any provider that is not directly or indirectly employed by or does not have a provider agreement with the contractor or any of its subcontractors pursuant to the contract between the department and the contractor.

“*PACE*” means the program for all-inclusive care for the elderly.

“*Participating providers*” means the providers of covered physical health, behavioral health and long-term care services that have contracted with a managed care organization.

“*PMIC*” means a psychiatric medical institution for children.

“*Prior authorization*” means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

“*Warm transfer*” means a telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.2(249A) Contracts with a managed care organization.**

**73.2(1)** The department may enter into a contract with a managed care organization licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as defined in rule 441—73.6(249A).

**73.2(2)** The department shall determine that the managed care organization meets the following requirements:

*a.* The managed care organization shall make available the services it provides to enrollees as established in the contract.

*b.* The managed care organization shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the managed care organization's debts if the managed care organization becomes insolvent. The managed care organization shall comply with insurance division provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

*c.* The managed care organization shall attain and maintain accreditation by the National Committee on Quality Assurance (NCQA) or URAC (formerly known as the Utilization Review Accreditation Commission).

**73.2(3)** If not already accredited, the managed care organization must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the managed care organization must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with insurance division rules set forth in 191—Chapter 40.

**73.2(4)** The contract shall meet the following minimum requirements. The contract shall:

*a.* Be in writing.

*b.* Specify the duration of the contract period.

*c.* List the services which must be covered.

*d.* Describe service access and provide access information.

*e.* List conditions for nonrenewal, termination, suspension, and modification.

*f.* Specify the method and rate of reimbursement.

*g.* Provide for disclosure of ownership and subcontracted relationships.

*h.* Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the managed care organization, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

*i.* Specify appeal and grievance rights.

*j.* Specify all operational and service delivery expectations.

*k.* Specify reporting requirements.

*l.* Specify requirements for utilization management and quality improvement.

*m.* Specify requirements for program integrity.

*n.* Specify termination requirements and assessment of penalties.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.3(249A) Enrollment.**

**73.3(1)** *Enrollment area.* The coverage area for enrollment shall be statewide.

**73.3(2)** *Members subject to enrollment.* All HAWK-I program and Iowa Health and Wellness Plan members shall be subject to mandatory enrollment in a managed care organization. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in a managed care organization:

*a.* Members who are medically needy as defined at 441—subrule 75.1(35).

*b.* Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements, pursuant to 441—subrule 75.11(4).

*c.* Persons who are currently presumptively eligible as defined in 441—subrules 75.1(30), 75.1(40), and 75.1(44).

*d.* Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as defined in 441—subrule 88.24(1).

*e.* Persons enrolled in the health insurance premium payment program (HIPP) pursuant to rule 441—75.21(249A).

*f.* Persons eligible only for the Medicare savings program as defined in rules 441—75.1(249A) and 441—76.1(249A).

*g.* American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

**73.3(3) Enrollment process.** The department shall notify members who must be enrolled in a managed care organization of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to October 16, 2015.

*a. General.* Members may receive managed care organization choice counseling from the enrollment broker. The enrollment broker will provide information about individual managed care organization benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

*b. Tentative assignment.* Members shall be tentatively assigned to a managed care organization and offered the opportunity to choose from the available managed care organizations within a time frame specified in the tentative assignment letter.

*c. Request to change enrollment.*

(1) A member shall have a minimum of ten days from the date of the tentative assignment letter to request enrollment with a different managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

(2) An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

*d. Ongoing enrollment.* Enrollees shall remain enrolled with the chosen managed care organization for a total of 12 months.

*e. Enrollment cycle.* Prior to the end of the enrollee's annual enrollment period, the enrollee shall be notified of the option to maintain enrollment with the current managed care organization or to enroll with a different managed care organization.

**73.3(4) Effective date of enrollment.** The effective date of enrollment shall be no later than the first day of the second month beginning after the date on which the managed care organization receives the designated managed health care choice form or written or verbal request.

**73.3(5) Benefit reimbursement prior to enrollment.**

*a.* Prior to the effective date of managed care enrollment, except as provided in paragraph 73.3(5) "b," the Medicaid program shall reimburse providers for covered program benefits pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

*b.* The managed care organization shall be responsible for covering newly retroactive Medicaid eligibility periods, prior to the effective date of enrollment, in the following cases:

(1) Babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth; and

(2) Children enrolled in the HAWK-I program retroactive to the date of application. For purposes of this requirement, a retroactive Medicaid eligibility period is defined as a period of time up to three months prior to the Medicaid determination month.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.4(249A) Disenrollment process.**

**73.4(1) Enrollee-requested disenrollment.** An enrollee may request disenrollment with a managed care organization as follows:

*a.* During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment, for any reason, in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the managed care organization, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the managed care organization's grievance system. If the member does not experience resolution, the managed care organization shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The managed care organization does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment shall be determined by the department.

**73.4(2) *Disenrollment by department.*** Disenrollment will occur when:

a. The contract between the department and the managed care organization is terminated.

b. The enrollee becomes ineligible for Medicaid, the HAWK-I program or the Iowa Health and Wellness Plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the managed care organization will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care organization enrollment. See definition of "enrollee" in rule 441—73.1(249A).

d. The department has determined that participation in the HIP program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

e. Death of the enrollee.

f. The enrollee has changed residence to another state.

**73.4(3) *Managed care organization-requested disenrollment.*** A managed care organization shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health care needs or change in health care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs (except when the enrollee's continued enrollment seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception applies, the managed care organization shall provide evidence to the department that continued enrollment of an enrollee seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees. The managed care organization shall have methods by which the department is assured that disenrollment is not requested for another reason.

**73.4(4) *Disenrollment effective date.*** The effective date of a department-approved disenrollment shall be no later than the first day of the second calendar month beginning after the month in which: (1) the enrollee requests disenrollment pursuant to subrule 73.4(1); (2) the department notifies the enrollee and managed care organization of disenrollment pursuant to subrule 73.4(2); or (3) the managed care organization requests disenrollment pursuant to subrule 73.4(3). The enrollee shall remain enrolled in the managed care organization and the managed care organization will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the managed care organization shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.5(249A) Covered services.**

**73.5(1) *Required services.*** A managed care organization shall provide:

a. For enrollees other than Iowa Health and Wellness Plan enrollees and HAWK-I program enrollees, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

- (1) Area education agency services.
  - (2) Dental services not provided in an outpatient hospital setting.
  - (3) Infant and toddler program services.
  - (4) Local education agency services.
  - (5) State of Iowa Veterans Home services.
  - (6) Money Follows the Person Grant-funded services.
- b. Services as set forth in 441—Chapter 74 for Iowa Health and Wellness Plan enrollees.
- c. Services as set forth in 441—Chapter 86 for HAWK-I program enrollees.

**73.5(2) Community-based case management service.** The managed care organization is required to provide services that meet requirements specified in the contract and in 441—subrule 90.5(1).

**73.5(3) Health home services.** The managed care organization is required to provide services that meet the requirements specified in 441—subrule 78.53(1) and as specified in the contract.

**73.5(4) Value-added services.** A managed care organization may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.6(249A) Amount, duration and scope of services.**

**73.6(1)** The managed care organization shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the agency. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3) as amended to October 16, 2015, the managed care organization shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The managed care organization may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, the managed care organization shall require as a condition of payment managed care organization approval of admissions to a nursing facility, an intermediate care facility for persons with an intellectual disability, psychiatric medical institutions for children, and a mental health institute. Managed care organizations shall also require managed care organization approval of out-of-state placements as a condition of payment.

**73.6(2)** The managed care organization may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The managed care organization shall not:

- a. Avoid costs for services covered in the contract by referring members to publicly supported health care resources.
- b. Deny reimbursement of covered services based on the presence of a preexisting condition.

**73.6(3)** The managed care organization shall allow each enrollee to choose a health professional, to the extent possible and appropriate, within the managed care organization's provider network. The managed care organization shall ensure compliance with the Americans with Disabilities Act (ADA) in the delivery and approval of all services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.7(249A) Emergency services.**

**73.7(1)** Emergency services shall be available 24 hours a day, 7 days a week.

**73.7(2)** In accordance with federal funding requirements, including 42 CFR 438.114 as amended to October 16, 2015, the managed care organization shall:

- a. Cover emergency services without the need for prior authorization and may not limit reimbursement to network providers.

*b.* Cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the managed care organization.

*c.* Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

*d.* Cover the medical screening examination, as defined by EMTALA, provided to a member who presents to an emergency department with an emergency medical condition.

**73.7(3)** The managed care organization shall not deny payment for:

*a.* Treatment obtained when an enrollee has an emergency medical condition, including cases in which the absence of immediate medical attention would result in placing the health of the enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

*b.* Treatment obtained when a representative of the managed care organization instructs the enrollee to seek emergency medical services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.8(249A) Access to service.**

**73.8(1)** The managed care organization shall ensure enrollees have access to services as specified in the contract. In general, the managed care organization shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, 7-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

**73.8(2)** Choice of providers. An enrollee shall use the managed care organization's provider network unless the managed care organization has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2) as amended to October 16, 2015, the managed care organization shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers who are not in the managed care organization's network.

**73.8(3)** Continuity of care. The managed care organization shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

**73.8(4)** Adequate service referral support and after-hours call-in coverage. The managed care organization shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

*a. Member helpline.* The managed care organization shall maintain a dedicated toll-free member services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal managed care organization departments, such as to care coordinators.

*b. Nurse call line.* The managed care organization shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, 7 days a week from trained medical professionals.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.9(249A) Incident reporting.** The managed care organization shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS Waivers, the Section 1915(i) Habilitation Program, and as required for licensure of programs through the department of inspections

and appeals. The managed care organization shall develop and implement policies and procedures, subject to department review and approval, to:

1. Address and respond to incidents;
2. Report incidents to the appropriate entities in accordance with required time frames; and
3. Track and analyze incidents.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.10(249A) Discharge planning.** The managed care organization shall establish policies and procedures, subject to approval by the department, that protect an individual from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The managed care organization shall facilitate a seamless transition whenever a member transitions between facilities or residences.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.11(249A) Level of care assessment and annual reviews.** The managed care organization shall establish policies and procedures to ensure the implementation of level of care and needs-based eligibility assessments and reassessments as required in the contract and consistent with the department's level of care and needs-based eligibility assessment process and the requirements provided in 441—Chapters 75, 78, 81, 82, 83, and 85. Waiver level of care determinations must be consistent with those made for the appropriate institutional level of care under the state plan.

**73.11(1) Initial level of care assessment.** Managed care organizations are responsible for conducting level of care and needs-based eligibility assessments for a current enrollee who requires a level of care or a needs-based eligibility assessment. The managed care organization shall perform the assessment using department-approved assessment tools. The results of the assessment shall be submitted to the IME medical services unit for determination of level of care or needs-based eligibility.

**73.11(2) Annual continued stay reviews, continued care reviews and redeterminations.** When an enrollee requires a continued stay review, a continued care review or a redetermination, the managed care organization shall use department-approved assessment tools. If the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect the enrollee's level of care or needs-based eligibility, the managed care organization shall submit the assessment findings to the IME medical services unit for determination of level of care or needs-based eligibility.

**73.11(3) At any time, if the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect level of care or needs-based eligibility, the managed care organization shall conduct a level of care or needs-based assessment using the department-approved tools and submit the assessment to the IME medical services unit for determination of level of care or needs-based eligibility.**

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.12(249A) Appeal of managed care organization actions.** The managed care organization shall have written appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal a managed care organization action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438.400(b) as amended to October 16, 2015.

**73.12(1) Managed care organization appealable actions.** Managed care organization actions that may be appealed include:

- a. Denial or limited authorization of a requested service, including the type or level of service.
- b. Reduction, suspension, or termination of a previously authorized service.
- c. Denial, in whole or in part, of payment of service.
- d. Failure to provide services in a timely manner as defined by the department.
- e. Failure of the managed care organization to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b) as amended to October 16, 2015.

*f.* For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.

**73.12(2) Appeal process.** The managed care organization appeal process shall be approved by the department and shall:

*a.* Allow for the appeal request to be submitted in writing or verbally. If the request is submitted verbally, it must be followed up with a written submission.

*b.* Require acknowledgment of the receipt of a request for an appeal within three working days.

*c.* Allow for participation by the enrollee and the provider.

*d.* Provide for resolution of nonexpedited appeals to be concluded within 45 calendar days of receipt of the request unless an extension is requested.

*e.* Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within three business days of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to October 16, 2015.

*f.* Ensure that the review will be made by qualified professionals who were not involved with the original action.

*g.* Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.13(249A) Appeal to department.** If the enrollee is not satisfied with the final decision rendered by the managed care organization through the managed care organization's appeal process, the enrollee may appeal an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.14(249A) Continuation of benefits.** The managed care organization shall be required to continue the member's benefits during the appeal in accordance with federal funding requirements, including 42 CFR 438.420 as amended to October 16, 2015.

**73.14(1)** If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

*a.* The enrollee withdraws the appeal request;

*b.* Ten days pass after the MCO mailed the notice providing the resolution of the appeal against the enrollee, unless the enrollee, within the ten-day time frame, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or

*c.* The time period or service limits of a previously authorized service have been met.

**73.14(2)** If the final resolution of the appeal is adverse to the enrollee, that is, it upholds the managed care organization's action, the managed care organization may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that services were furnished solely because of the requirements to maintain benefits during the appeal.

**73.14(3)** If the managed care organization or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If the managed care organization or the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the managed care organization must pay for these services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.15(249A) Grievances.** The managed care organization shall have policies and procedures for review of any nonclinical incidents, nonclinical complaints, or nonclinical concerns. Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than

the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.16(249A) Written record.** All enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.17(249A) Information concerning procedures relating to the review of managed care organization decisions and actions.** The managed care organization's written procedures for the review of managed care organization decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.18(249A) Records and reports.**

**73.18(1) Records system.** The managed care organization shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including rule 441—79.3(249A) and 42 CFR 456 as amended to October 16, 2015, throughout the course of the contract. The records system shall:

*a.* Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.

*b.* Provide a rationale for and documentation of decisions made by the managed care organization, based upon medical necessity.

*c.* Permit effective professional review for medical audit processes.

*d.* Facilitate an adequate system for monitoring treatment reimbursed by the managed care organization including follow up of the implementation of discharge plans and referral to other providers.

**73.18(2) Content of individual treatment record.** The managed care organization shall ensure that participating providers maintain an adequate record-keeping system that includes a complete medical or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of rule 441—79.3(249A) and pursuant to federal funding requirements, including 42 CFR 456 as amended to October 16, 2015.

**73.18(3) Confidentiality of health care, mental health care, and substance abuse information.** The managed care organization shall protect and maintain the confidentiality of health care, mental health care, and substance abuse information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.19(249A) Audits.** The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the managed care organization. The department or HHS may audit and inspect any records of a managed care organization, or the subcontractor of the managed care organization, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.20(249A) Marketing.** Managed care organization marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the managed care organizations and contract terms. The department shall approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.21(249A) Enrollee education.**

**73.21(1) Use of services.** The managed care organization shall provide written information to all enrollees on the use of services the managed care organization is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of managed care organization decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

**73.21(2) Outreach to members with special needs.** The managed care organization shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, an intellectual disability or other cognitive impairments, illiterate persons, non-English-speaking persons, and persons with visual or hearing impairments.

**73.21(3) Patient rights and responsibilities.** The managed care organization shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.22(249A) Payment to the managed care organization.**

**73.22(1) Capitation rate.** In consideration for all services rendered by a managed care organization under a contract with the department, the managed care organization will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms defined in the managed care contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act, the health insurance providers fee. This capitation rate, inclusive of the amounts withheld and the health insurance providers fee, represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled members under the contract except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the managed care organization meets metrics defined in the managed care contract.

**73.22(2) Determination of rate.** The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6 as amended to October 16, 2015, Actuarial Standards of Practice 49, and other related CMS regulations and generally accepted actuarial principles and practices.

**73.22(3) Third-party liability.** If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses, it is the right and responsibility of the managed care organization to investigate these third-party resources and attempt to obtain payment. The managed care organization shall retain all funds collected from third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

**73.22(4) Medical loss ratio.** The managed care organization shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the managed care organization.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.23(249A) Claims payment by the managed care organization.**

**73.23(1)** The managed care organizations shall pay or deny:

- a. Ninety percent of all clean claims within 14 calendar days of receipt,
- b. Ninety-nine point five percent of all clean claims within 21 calendar days of receipt, and
- c. One hundred percent of all claims within 90 calendar days of receipt.

**73.23(2)** Limits on payment responsibility for services.

*a.* The managed care organization is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

*b.* The managed care organization has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

*c.* Payment responsibilities for emergency room services are as provided at rule 441—73.7(249A).

**73.23(3)** Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.24(249A) Quality assurance.** The managed care organization shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.25(249A) Certifications and program integrity.** The managed care organization shall develop and implement policies, procedures and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The managed care organization shall cooperate and collaborate with the department on all program integrity activities. The managed care organization shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

These rules are intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, section 12.

[Filed Emergency After Notice ARC 2358C (Notice ARC 2241C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]



CHAPTER 74  
IOWA HEALTH AND WELLNESS PLAN

PREAMBLE

This chapter defines and structures the Iowa Health and Wellness Plan, effective January 1, 2014, and administered by the department pursuant to 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187. Implementation of the Iowa Health and Wellness Plan is subject to approval by the Secretary of the United States Department of Health and Human Services of any waivers of the requirements of Title XIX of the Social Security Act to provide for federal funding of the plan. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

**441—74.1(249A,85GA,SF446) Definitions.**

“*Caretaker relative*” means a relative listed in 441—subrule 75.55(1).

“*Countable income*” means “modified adjusted gross income” (MAGI) or “household income,” as applicable, determined pursuant to 42 U.S.C. § 1396a(e)(14).

“*Department*” means the Iowa department of human services.

“*Enrollment period*” means the 12-month period for which Iowa Health and Wellness plan eligibility is established.

“*Essential health benefits*” means the essential health benefits defined at 42 U.S.C. § 18022.

“*Federal poverty level*” means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

“*Health insurance marketplace*” or “*exchange*” means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“*Iowa Health and Wellness Plan*” means the medical assistance program set forth in this chapter.

“*Iowa wellness plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Marketplace choice plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level.

“*Medical home*” means a provider contracted with the department through Form 470-5177, Agreement for Participation as a Patient Manager in the Iowa Health and Wellness Plan (Wellness Plan).

“*Medically exempt individual*” means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR § 440.315 as amended on July 15, 2013.

“*Member*” means an individual who is receiving assistance under the Iowa Health and Wellness Plan described in this chapter.

“*Minimum essential coverage*” means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

“*Modified adjusted gross income*” means the financial-eligibility methodology prescribed in 42 U.S.C. § 1396a(e)(14).

“*Qualified employer-sponsored coverage*” shall be defined pursuant to 42 U.S.C. § 1396e-1(b).

“*Qualified health plan*” shall be defined pursuant to Section 1301 of the Patient Protection and Affordable Care Act, Public Law 111-152.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—74.2(249A,85GA,SF446) Eligibility factors.** Except as more specifically provided in this chapter, Iowa Health and Wellness Plan eligibility shall be determined according to the requirements of 441—Chapter 75.

**74.2(1) Persons covered.** Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under the Iowa Health and Wellness Plan shall be available to persons 19 through 64 years of age who:

- a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;
- b. Have countable income at or below 133 percent of the federal poverty level for their household size; and
- c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and
- d. Are not pregnant.

**74.2(2) Parents or caretakers of dependent children.** All children under the age of 21 living with a parent or other caretaker relative who will be claimed as a dependent by the parent or caretaker relative for state or federal income tax purposes must be enrolled in Medicaid, in the Children's Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent's or other caretaker relative's eligibility for Iowa Health and Wellness Plan benefits.

**74.2(3) Citizenship.** To be eligible for Iowa Health and Wellness Plan benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

**441—74.3(249A,85GA,SF446) Application.** Medicaid application policies and procedures described in 441—Chapter 76 shall apply to applications for the Iowa Health and Wellness Plan.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

**441—74.4(249A,85GA,SF446) Financial eligibility.**

**74.4(1) Countable income.** Individuals are financially eligible for the Iowa Health and Wellness Plan if their countable income is no more than 133 percent of the federal poverty level, as of the date of a decision on initial or ongoing eligibility.

**74.4(2) Household size.** For financial eligibility purposes, household size shall be determined according to the modified adjusted gross income (MAGI) methodology.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

**441—74.5(249A,85GA,SF446) Enrollment period.**

**74.5(1) Effective dates of eligibility.** Iowa Health and Wellness Plan eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period shall continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,85GA,SF446).

**74.5(2) Retroactive enrollment.** Medical assistance shall be available for all or any of the three months preceding the month in which an application is filed in accordance with 441—subrule 76.13(2).

**74.5(3) Reinstatement.** Enrollment for the Iowa Health and Wellness Plan may be reinstated without a new application in accordance with 441—subrule 76.12(2).

**74.5(4) Presumptive eligibility.** The enrollment period of 12 consecutive months shall not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with rules 441—76.7(249A) and 441—76.13(249A).

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

**441—74.6(249A,85GA,SF446) Reporting changes.**

**74.6(1) Reporting requirements.** As a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member turns 65.

- d. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
- e. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
- f. The member's countable income increases in a manner that must be reported according to the requirements of rule 441—76.15(249A).
- g. The member is confirmed pregnant.

**74.6(2) *Untimely report.*** When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible shall be considered an overpayment and be subject to recovery from the member in accordance with rule 441—75.28(249A) and 441—Chapter 11. Program expenditures may include, but are not limited to, premiums and capitation payments.

**74.6(3) *Effective date of change.*** After enrollment, changes reported during the month that affect the member's eligibility shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or
  - b. The enrollment period has expired and the member is not eligible for a new enrollment period.
- [ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

**441—74.7(249A,85GA,SF446) *Reenrollment.*** A new eligibility determination is required for consecutive 12-month enrollment periods. The reenrollment process will follow the requirements in 441—subrule 76.14(2).

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

**441—74.8(249A,85GA,SF446) *Terminating enrollment.*** Iowa Health and Wellness Plan enrollment shall end when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the federal poverty level.
10. The member reports that she is pregnant.
11. The Iowa Health and Wellness Plan is discontinued according to the requirements in rule 441—74.14(249A,85GA,SF446).
12. The member does not pay monthly contributions as required by subrule 74.11(2).

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

**441—74.9(249A,85GA,SF446) *Recovery.*** The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with rule 441—75.28(249A).

**74.9(1)** The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with rule 441—75.28(249A).

**74.9(2)** Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

**441—74.10(249A,85GA,SF446) Right to appeal.**

**74.10(1)** Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. A provider requesting a hearing on behalf of a member must have the prior express written consent of the member or the member's lawfully appointed guardian. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the provider submits a document providing the member's consent to the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily, and intelligently consents to the provider's bringing the state fair hearing on the member's behalf.

**74.10(2)** Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,85GA,SF446).

**74.10(3)** Coverage decisions and actions by participating marketplace choice plans must first be appealed through the plan's internal appeal process and through the external review process pursuant to Iowa Administrative Code 191—Chapter 76. After a member has exhausted the member's rights under the external review process, the member may appeal a decision or action pursuant to 441—Chapter 7. Appeal requests made pursuant to 441—Chapter 7 shall result in a change from benefits and service delivery under subrule 74.12(2) to benefits and service delivery under subrule 74.12(1). Benefits and service delivery under subrule 74.12(1) shall remain in effect for the remainder of the member's eligibility period.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

**441—74.11(249A,85GA,SF446) Financial participation.**

**74.11(1) Copayment.** Payment for nonemergency use of a hospital emergency department shall be subject to an \$8 copayment by the member, which shall be subtracted from the Iowa Health and Wellness Plan payment otherwise due to the provider. This copayment will be waived during calendar year 2014.

**74.11(2) Monthly contributions.** Members enrolled in the Iowa Health and Wellness Plan with household income at or above 50 percent of the federal poverty level are required to pay monthly contributions pursuant to this rule.

*a. Monthly contribution amount.* The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to rule 441—75.70(249A), as a percentage of the federal poverty level (FPL) for the household. Monthly contribution amounts are as follows:

- (1) For a member with household income between 50 and 100 percent of the FPL, \$5;
- (2) For a member with household income above 100 percent of the FPL, \$10.

*b. Waiver during the first year of enrollment.* The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

*c. Monthly contribution exemptions.* A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

- (1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.
- (2) The member is determined to be a medically exempt individual pursuant to subrule 74.12(3).
- (3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.
- (4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department, by checking the hardship box on the billing statement (for the month of

the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.

*d. Billing and payment.* Form 470-5285, Iowa Health and Wellness Plan Billing Statement, shall be used for billing and collection.

(1) Method of payment. Members shall submit contribution payments to the following address: Iowa Medicaid Enterprise, Iowa Health and Wellness Plan Monthly Contributions, P.O. Box 14485, Des Moines, Iowa 50306-3485.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution for each month is due on the last calendar day of the month that the monthly contribution is to cover.

2. If the last calendar day falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department shall apply monthly contributions payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

*e. Failure to pay monthly contributions.*

(1) An Iowa wellness plan member who fails to pay the assessed monthly contributions and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with rule 441—75.28(249A). A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) A marketplace choice plan member who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall have the member's eligibility terminated. In addition, the unpaid monthly contribution shall be subject to recovery in accordance with rule 441—75.28(249A) as an unpaid premium.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions must reenroll for Medicaid benefits pursuant to 441—Chapter 76.

*f. Refund of monthly contributions.*

(1) Monthly contributions paid for any period shall be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2) "c" or when a member's Iowa Health and Wellness Plan coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in the Iowa Health and Wellness Plan; or

2. The member dies.

(2) The amount of any refund shall be offset by any outstanding monthly contributions owed.

(3) The refund shall be paid within two calendar months.

**74.11(3) Aggregate annual limits on copayments and monthly contributions.** The total aggregate annual amount of copayments and monthly contributions for an individual shall not exceed 5 percent of the household's countable annual income determined pursuant to rule 441—75.70(249A).

**74.11(4) Healthy behaviors.** An Iowa Health and Wellness Plan member who completes a wellness examination and health risk assessment during any enrollment year shall have monthly contributions waived in the subsequent enrollment year.

*a.* Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations

and as defined by the department. Oral examinations must be performed by a dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

*b.* A health risk assessment must be one of the following:

(1) An “Assess My Health” assessment offered through the department;

(2) An assessment offered by a managed care plan through which the member is receiving Iowa Health and Wellness Plan benefits; or

(3) An assessment offered by a qualified health plan through which the member is receiving Iowa Health and Wellness Plan benefits.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—74.12(249A,85GA,SF446) Benefits and service delivery.** Covered benefits and the service delivery method shall be determined by the member’s countable income and health status.

**74.12(1) Iowa wellness plan services.** Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level shall be enrolled in the Iowa wellness plan unless the member is determined by the department to be a medically exempt individual. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for Iowa wellness plan services.

*a.* Covered Iowa wellness plan services are essential health benefits, all other benefits required pursuant to 42 U.S.C. § 1396u-7(b)(1)(B), including prescription drugs, and dental services consistent with 441—Chapter 78.

*b.* Members enrolled in the Iowa wellness plan shall be subject to enrollment in managed care, other than PACE programs, pursuant to 441—Chapter 88.

*c.* Dental services shall be provided through a contract with one or more commercial dental plans. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

**74.12(2) Marketplace choice plan services.** At the department’s discretion, Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level may be enrolled in a marketplace choice plan unless the member is determined by the department to be a medically exempt individual. At the department’s discretion, marketplace choice coverage may be provided through designated qualified health plans available on the health insurance marketplace. Covered services not provided by the marketplace choice plan will be provided by the medical assistance program.

*a.* Upon enrollment, a member shall choose a qualified health plan from those designated by the department to provide coverage to marketplace choice plan members.

*b.* When the member does not select a qualified health plan pursuant to notice of the need to do so, the department will select a plan, enroll the member, and notify the member of the assigned plan.

*c.* The department shall pay premiums to designated qualified health plans participating on the health insurance marketplace to buy coverage for eligible marketplace choice plan members. The department shall begin payment of the member’s premiums for the first month of enrollment in the qualified health plan. The qualified health plan shall provide the member with an insurance card identifying the member as an enrollee of the plan. The department shall provide the member with a medical assistance eligibility card for covered medical services not provided by the qualified health plan.

*d.* Covered services are all benefits, including essential health benefits, provided by the designated qualified health plan on the health insurance marketplace, including prescription drugs. Services not covered by the qualified health plan, but covered pursuant to the marketplace choice 1115 waiver or the marketplace choice state plan will be covered by the Medicaid program.

*e.* Dental services shall be provided through a contract with one or more commercial dental plans with covered services consistent with 441—Chapter 78. The department may restrict member access to

those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

**74.12(3) *Medically exempt individuals.*** An Iowa Health and Wellness Plan member who has been determined by the department to be a medically exempt individual shall be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

*a.* A member may attest to being a medically exempt individual by submitting a completed Form 470-5194.

*b.* A provider with a current National Provider Identifier number, an employee of the department of human services, a designee of the department of corrections, a qualified health plan, or a mental health and disability services region established pursuant to Iowa Code sections 331.388 to 331.399 may refer a member for a medically exempt individual determination by submitting a completed Form 470-5196, Medically Exempt Attestation and Referral Form.

*c.* Upon receipt of Form 470-5194 or 470-5196, the Iowa Medicaid enterprise shall determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR § 440.315 as amended on July 15, 2013.

**74.12(4) *Qualified employer-sponsored coverage.*** An individual who has access to cost-effective employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—74.13(249A,85GA,SF446) Claims and reimbursement methodologies.**

**74.13(1) *Claims for services not provided by a qualified health plan.*** Claims for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be submitted to the Iowa Medicaid enterprise as required by 441—Chapter 80 or to the member's Medicaid managed care organization.

**74.13(2) *Payment for services not provided by a qualified health plan.*** Payment for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member's Medicaid managed care organization and the provider.

**74.13(3) *Payment for services provided by the marketplace choice plan.*** Payment for services provided under the marketplace choice plan shall be made in accordance with the rates filed with the Iowa insurance division.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—74.14(249A,85GA,SF446) Discontinuance of program.**

**74.14(1)** If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for the Iowa Health and Wellness Plan is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

**74.14(2)** If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services shall be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

**441—74.15(249A,85GA,ch138) Enrollment for IowaCare members.** Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16.

These rules are intended to implement 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187, and Iowa Code chapter 249A.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]

[Filed Emergency ARC 1214C, IAB 12/11/13, effective 11/13/13]

[Filed ARC 1354C (Notice ARC 1213C, IAB 12/11/13), IAB 3/5/14, effective 4/9/14]

[Filed ARC 1698C (Notice ARC 1618C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]

[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

CHAPTER 75  
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]  
[Prior to 7/1/83, Social Services[770] Ch 75]  
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes the conditions of eligibility for the medical assistance program administered by the department of human services pursuant to Iowa Code chapter 249A and addresses related matters. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.  
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

DIVISION I  
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

**441—75.1(249A) Persons covered.**

**75.1(1)** *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

- a. Persons denied RCA because the amount of payment would be less than \$10.
- b. Rescinded IAB 7/30/08, effective 10/1/08.
- c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

**75.1(2)** Rescinded IAB 10/8/97, effective 12/1/97.

**75.1(3)** *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

**75.1(4)** *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

**75.1(5)** *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

**75.1(6)** *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

**75.1(7)** *Persons receiving care in a medical facility who would be eligible under a special income standard.*

- a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:
  - (1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).
  - (2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

*b.* For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

*c.* Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A “period of 30 days” is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain “under the jurisdiction of the institution” a person must first have been physically admitted to the institution.

**75.1(8)** *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of “essential person” in effect in the public assistance program on December 31, 1973.

**75.1(9)** *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249.

**75.1(10)** *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

*a.* The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

*b.* The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

**75.1(11)** *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

*a.* The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

*b.* Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

- (1) Failure to provide information, or
- (2) Failure to comply with other procedural requirements.

**75.1(12)** *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

**75.1(13)** *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

- a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and
- b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and
- c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

**75.1(14)** *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

- a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed \$2,000 for applicant households or \$5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.
- b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).
- c. Rescinded IAB 11/1/00, effective 1/1/01.

**75.1(15)** *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2) "a," "b," "c," and "d" shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1) "a" but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8) "c" and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

**75.1(16)** *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

**75.1(17)** *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

**75.1(18)** *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

**75.1(19)** *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the \$30 or the \$30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

**75.1(20)** *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins

with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

**75.1(21)** *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

**75.1(22)** *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

**75.1(23)** *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

**75.1(24)** *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

**75.1(25)** *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

**75.1(26)** Rescinded IAB 10/8/97, effective 12/1/97.

**75.1(27)** *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

**75.1(28)** *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8) "b" and "c," shall be treated in accordance with paragraphs 75.57(9) "b" and "c."

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed \$10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

*f.* An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

*g.* Rescinded IAB 11/1/89, effective 1/1/90.

*h.* When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

*i.* A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

*j.* If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

**75.1(29)** *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

*a.* The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

*b.* The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

*c.* The effective date of eligibility is the first of the month after the month of decision.

**75.1(30)** *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

*a.* A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

*b.* The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

*c.* Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

*d.* In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

*e.* Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

*f.* The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

*g.* A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

**75.1(31)** *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, “family” shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. “Family” also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

*a.* Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

*b.* In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

*c.* The 12 months’ Medicaid transitional coverage begins the day following termination of FMAP eligibility.

*d.* When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph “*f*” below apply.

*e.* Rescinded IAB 8/12/98, effective 10/1/98.

*f.* Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

*g.* During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

*h.* If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs “*g*” and “*i*” of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)“*f*” and 75.57(2)“*l*.”

*i.* Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional

six-month period as required in paragraph 75.1(31)“h,” unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The family offers a good cause beyond the family’s control.
4. There was a failure to receive the department’s notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client’s achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family’s average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

*j.* These provisions apply to specified relatives defined at paragraph 75.55(1)“a,” including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

*k.* The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph “g” or “i” above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

**75.1(32)** *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

*a.* An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

*b.* A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

**75.1(33)** *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

*a.* Qualified disabled and working persons are persons who meet the following requirements:

(1) The person’s monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person’s resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

*b.* The amount of the person’s income and resources shall be determined as under the SSI program.

**75.1(34) Specified low-income Medicare beneficiaries.** Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

*a.* The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

*b.* The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

*c.* The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

*d.* The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

**75.1(35) Medically needy persons.**

*a. Coverage groups.* Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

*b. Resources and income of all persons considered.*

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

*c. Resources.*

(1) The resource limit for adults in SSI-related households shall be \$10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be \$10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

*d. Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9) “b,” “c,” “g,” “h,” and “i” regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months’ net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

*e. Medically needy income level (MNIL).*

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	\$483	\$483	\$566	\$666	\$733	\$816	\$891	\$975	\$1058	\$1158

Each additional person \$116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35) “b” shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

*f. Verification of medical expenses to be used in spenddown calculation.* The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the

provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

*g. Spenddown calculation.*

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.
3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs “1” through “3” above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

*h. Medicaid services.* Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

*i. Reviews.* Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

*j. Redetermination.* When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

*k. Recertifications.* A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

*l. Disability determinations.* An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.
- (3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

**75.1(36) Expanded specified low-income Medicare beneficiaries.** As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

- a. The person is not otherwise eligible for Medicaid.
- b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.
- c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.
- d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.
- e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

**75.1(37) Home health specified low-income Medicare beneficiaries.** Rescinded IAB 10/30/02, effective 1/1/03.

**75.1(38) Continued Medicaid for disabled children from August 22, 1996.** Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

**75.1(39) Working persons with disabilities.**

- a. Medical assistance shall be available to all persons who meet all of the following conditions:
  - (1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.
  - (2) They are less than 65 years of age.
  - (3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.
  - (4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39)“c.”
  - (5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)“a”(1) above.
  - (6) They have paid any premium assessed under paragraph 75.1(39)“b” below.
- b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social

security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established based on projected average monthly income. The monthly premium established shall not be increased for any reason before the next eligibility review. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$32
165% of Federal Poverty Level	\$44
180% of Federal Poverty Level	\$53
200% of Federal Poverty Level	\$62
225% of Federal Poverty Level	\$73
250% of Federal Poverty Level	\$84
300% of Federal Poverty Level	\$106
350% of Federal Poverty Level	\$130
400% of Federal Poverty Level	\$153
450% of Federal Poverty Level	\$177
550% of Federal Poverty Level	\$221
650% of Federal Poverty Level	\$268
750% of Federal Poverty Level	\$316
850% of Federal Poverty Level	\$375
1000% of Federal Poverty Level	\$451
1150% of Federal Poverty Level	\$530
1300% of Federal Poverty Level	\$612
1480% of Federal Poverty Level	\$707

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(8) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to Form 470-3902, MEPD Billing Statement.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3902, MEPD Billing Statement, shall be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit Form 470-4856, MEPD Intent to Return to Work, to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

*"Assistive technology"* is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

*"Assistive technology accounts"* include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

*"Assistive technology device"* is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

*"Assistive technology service"* means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It

includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

*“Family,”* if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, *“family”* includes the individual’s spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual’s family. An individual living alone or with others not listed above shall be considered to be a family of one.

*“Medical savings account”* means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

*“Retirement account”* means any retirement or pension fund or account, listed in Iowa Code section 627.6(8) *“f”* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

**75.1(40)** *People who have been screened and found to need treatment for breast or cervical cancer:*

*a.* Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

*b.* Eligibility established under paragraph *“a”* continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

*c.* Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph *“a”* shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or

- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer

screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

**75.1(41)** *Persons eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available as provided in this subrule.

*a. Eligibility.* The following are eligible for assistance under this coverage group if they are not otherwise enrolled in Medicaid (other than IowaCare):

(1) Women who were Medicaid members when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends.

(2) Women who have reached childbearing age, are under 55 years of age, are capable of bearing children but are not pregnant, and have income that does not exceed 305 percent of the federal poverty level, as determined according to paragraph 75.1(41)“c.”

(3) Men who are under 55 years of age, who are capable of fathering children, and who have income that does not exceed 305 percent of the federal poverty level, as determined according to paragraph 75.1(41)“c.”

*b. Application.*

(1) Women eligible under subparagraph 75.1(41)“a”(1) are not required to file an application for assistance under this coverage group. The department will automatically redetermine eligibility pursuant to rule 441—76.11(249A) upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

(2) A person requesting assistance based on subparagraph 75.1(41)“a”(2) or 75.1(41)“a”(3) shall file an application as required in rule 441—76.1(249A).

*c. Determining income eligibility.* The department shall determine the countable income of an applicant applying under subparagraph 75.1(41)“a”(2) or 75.1(41)“a”(3) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in subrule 75.54(1) living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Earned income. All earned income as defined in subrule 75.57(2) that is received by a member of the household shall be counted except for the earnings of a child who is a full-time student as defined in paragraph 75.54(1)“b.”

(3) Unearned income. The following unearned income of all household members shall be counted:

1. Unemployment compensation.

2. Child support.

3. Alimony.

4. Social security and railroad retirement benefits.

5. Worker’s compensation and disability payments.

6. Benefits paid by the Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

(4) Deductions. Deductions from income shall be made for any payments made by household members for court-ordered child support, alimony, or spousal support to non-household members and as provided in subrule 75.57(2).

(5) Disregard of changes. A person found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

*d. Effective date.* Assistance for family planning services under this coverage group shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. Notwithstanding 441—subrule 76.5(1), assistance shall not be available under this coverage group for any months preceding the month of application.

**75.1(42) Medicaid for independent young adults.** Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

*a.* The person is at least 18 years of age and under 21 years of age.

*b.* On the person’s eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.

c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.

d. The person has income below 200 percent of the most recently revised federal poverty level for the person's household size.

(1) "Household" shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person's own children;
2. The person's spouse; and
3. Any children of the person's spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person's household. A person who lives alone or with others not listed above, including the person's parents, shall be considered a household of one.

(2) The department shall determine the household's countable income pursuant to rule 441—75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

**75.1(43) Medicaid for children with disabilities.** Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

**75.1(44) Presumptive eligibility for children.** Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. *Qualified entity.* A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

- (1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and
- (2) Has signed an agreement with the department as a qualified entity.

*b. Application process.* Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1) “f.” The qualified entity shall use the department’s Web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child’s presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

*c. Eligibility requirements.* To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household’s gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

*d. Period of presumptive eligibility.* Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for HAWK-I; or

(4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child’s eligibility during the presumptive period.

*e. Services covered.* Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

**75.1(45) Medicaid for former foster care youth.** Effective January 1, 2014, medical assistance shall be available to a person who meets all of the following conditions:

*a.* The person is at least 18 years of age (or such higher age to which foster care is provided to the person) and under 26 years of age;

*b.* The person is not described in or enrolled under any of Subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Social Security Act or is described in any of such subclauses but has income that exceeds the level of income applicable under Iowa’s state Medicaid plan for eligibility to enroll for medical assistance under such subclause;

c. The person was in foster care under the responsibility of Iowa on the date of attaining 18 years of age or such higher age to which foster care is provided; and

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Social Security Act while in such foster care.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7833B, IAB 6/3/09, effective 8/1/09; ARC 7929B, IAB 7/1/09, effective 7/1/09; ARC 7931B, IAB 7/1/09, effective 7/1/09; ARC 8095B, IAB 9/9/09, effective 10/14/09; ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8261B, IAB 11/4/09, effective 10/15/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8713B, IAB 5/5/10, effective 8/1/10; ARC 8897B, IAB 6/30/10, effective 9/1/10; ARC 9581B, IAB 6/29/11, effective 8/3/11; ARC 9647B, IAB 8/10/11, effective 8/1/11; ARC 9956B, IAB 1/11/12, effective 1/1/12; ARC 0149C, IAB 6/13/12, effective 8/1/12; ARC 0579C, IAB 2/6/13, effective 4/1/13; ARC 0820C, IAB 7/10/13, effective 8/1/13; ARC 0990C, IAB 9/4/13, effective 1/1/14; ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1482C, IAB 6/11/14, effective 8/1/14; ARC 2029C, IAB 6/10/15, effective 8/1/15]

**441—75.2(249A) Medical resources.** Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

**75.2(1)** The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

**75.2(2)** As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

- (1) File a claim or submit an application for any reasonably available medical resource, and
- (2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

**75.2(3)** Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

- a. Physical or emotional harm to the member for whom medical resources are being sought.
- b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

**75.2(4)** Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in

the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.  
[ARC 7546B, IAB 2/11/09, effective 4/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8785B, IAB 6/2/10, effective 8/1/10]

**441—75.3(249A) Acceptance of other financial benefits.** An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

**75.3(1)** When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

**75.3(2)** The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

**75.3(3)** When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

**75.3(4)** The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—75.4(249A) Medical assistance lien.**

**75.4(1)** When the medical assistance program pays for a member's medical care or expenses, the department shall have a lien upon all monetary claims which the member may have against third parties for those expenses. Monetary claims shall include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien shall be to the extent of the medical assistance payments only.

*a.* A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

*b.* The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

*c.* All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

**75.4(2)** The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien

under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

**75.4(3)** In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

*a.* The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

*b.* Rescinded IAB 9/4/91, effective 11/1/91.

*c.* The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

*d.* The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

*e.* When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or

legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

*f.* The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

**75.4(4)** Third party and provider responsibilities.

*a.* The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

*b.* The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

*c.* An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

**75.4(5)** Department's lien.

*a.* The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

*b.* When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

*c.* When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

*d.* The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

**75.4(6)** For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

**75.4(7)** The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

[ARC 9696B, IAB 9/7/11, effective 9/1/11; ARC 9881B, IAB 11/30/11, effective 1/4/12]

**441—75.5(249A) Determination of countable income and resources for persons in a medical institution.** In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

**75.5(1)** Determining income from property.

*a. Nontrust property.* Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

*b. Trust property.* Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

**75.5(2)** Division of income between married people for SSI-related coverage groups.

*a. Institutionalized spouse and community spouse.* If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

*b. Spouses institutionalized and living together.* Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

*c. Spouses institutionalized and living apart.* Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

**75.5(3)** Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

*a. When determined.* The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

*b. Information required.* The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

*c. Resources considered.* The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)“a” live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is \$1500 or less per spouse.

(10) An amount, not in excess of \$1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of \$1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

*d. Method of attribution.* The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than \$24,000, then \$24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

*e. Notice and appeal rights.* The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

- (1) That the attribution is incorrect, or
- (2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

*f. Appeals.* Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2) "d" shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3) "f"(5).

**75.5(4) Consideration of resources of married people.**

*a.* One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during

the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

*b.* One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

*c.* Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

*d.* Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

**75.5(5)** Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

*a. Eligibility.* A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule.

*b. Definition.* “Asset adjustment” shall mean a \$1 disregard of resources for each \$1 that has been paid out under the person’s qualified or approved long-term care insurance policy.

*c. Estate recovery.* An amount equal to the benefits paid out under a member’s qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member’s spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[ARC 8443B, IAB 1/13/10, effective 3/1/10]

**441—75.6(249A) Entrance fee for continuing care retirement community or life care community.** When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual’s Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual’s other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

**441—75.7(249A) Furnishing of social security number.**

**75.7(1)** As a condition of eligibility, except as provided by subrule 75.7(2), all social security numbers issued to each individual (including children) for whom Medicaid is sought must be furnished to the department.

**75.7(2)** The requirement of subrule 75.7(1) does not apply to an individual who:

*a.* Is not eligible to receive a social security number;

*b.* Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or

*c.* Refuses to obtain a social security number because of a well-established religious objection.

For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

**75.7(3)** If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

**441—75.8(249A) Medical assistance corrective payments.** If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

**75.8(1)** These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

**75.8(2)** Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

**75.8(3)** If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

**75.8(4)** Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

**75.8(5)** Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

**441—75.9(249A) Treatment of Medicaid qualifying trusts.**

**75.9(1)** A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

**75.9(2)** The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

*a.* Trust income considered available shall be counted as income.

*b.* Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

*c.* To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

**441—75.10(249A) Residency requirements.** Residency in Iowa is a condition of eligibility for medical assistance.

**75.10(1) Definitions.**

*a. Institutions.* For purposes of this rule, “institution” means an “institution” or a “medical institution” as those terms are defined in 42 CFR § 435.1010 as amended to July 13, 2007. For purposes of state placement, “institution” also includes foster care homes licensed as set forth in 45 CFR § 1355.20 as amended to January 6, 2012, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

*b. Incapable of expressing intent regarding residency.* For purposes of this rule, an individual is considered to be “incapable of indicating intent regarding residency” if the individual:

1. Has an IQ of 49 or less or has a mental age of seven or less;
2. Has been judged legally incompetent; or
3. Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

**75.10(2) Determination of residency.** State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency:

*a.* Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

*b.* Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to

that state when the purpose of the absence has been accomplished remains a resident of that state during the absence, unless another state has determined that the person is a resident there for Medicaid purposes.

*c.* Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

*d.* Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. § 1382e (including payments from Iowa pursuant to rules 441—50.1(249) through 441—54.8(249), 441—81.23(249A), 441—82.19(249A), 441—85.47(249A), or 441—177.1(249) through 441—177.11(249)) are considered to be residents of the state paying the supplementary assistance.

*e.* Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care or adoption assistance payments for a child under Title IV-E of the Social Security Act are considered to be residents of the state where the child lives.

*f.* Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

*g.* Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

*h.* Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

*i.* Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

*j.* Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

- (1) Intends to reside, with or without a fixed address; or
- (2) Entered with a job commitment or to seek employment, whether or not currently employed.

*k.* Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

*l.* Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is not incapable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2) "j."

*m.* Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2) "k" or "l," the state of residence is:

- (1) The state where the individual resides, with or without a fixed address; or
- (2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2) "j," with whom the individual resides.

This rule is intended to implement Iowa Code section 249A.3.  
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

#### **441—75.11(249A) Citizenship or alienage requirements.**

##### **75.11(1) Definitions.**

*"Care and services necessary for the treatment of an emergency medical condition"* means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

*"Emergency medical condition"* means a medical condition of sudden onset (including labor and delivery) 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 one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

*"Federal means-tested program"* means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.

5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.

6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;

- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and

- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

*"Qualified alien"* means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);

2. Who is granted asylum in the United States under Section 208 of the INA;

3. Who is a refugee admitted to the United States under Section 207 of the INA;

4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;

5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;

6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;

7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);

8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);

9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);

10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;

11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or

12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

*"Qualifying quarters"* includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

**75.11(2) Citizenship and alienage.**

a. To be eligible for Medicaid, a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien residing in the United States before August 22, 1996.

- (3) A qualified alien under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).
- (5) An alien who has been granted asylum under Section 208 of the INA.
- (6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
- (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
- (9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.
- (10) A qualified alien who has resided in the United States for a period of at least five years.
- (11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).
- (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
- (14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).
- (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

*b.* As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0462(S); or
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS).

*c.* Except as provided in paragraph "*f*," applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph "*b*" shall present satisfactory documentation of citizenship or nationality as defined in paragraph "*d*," "*e*," or "*i*." A reference to a form in paragraph "*d*" or "*e*" includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)"*i*"(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual

who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.5(1) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph “*d*,” “*e*,” or “*i*.” The retroactive months are outside the “reasonable period” during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

*d.* Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver’s license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

*e.* Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

*f.* A person for whom an attestation of United States citizenship has been made pursuant to paragraph “*b*” is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 75.11(2)"e"(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)"e"(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph "d" or "e," satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual's name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual's citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual's citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration's records, or to provide other documentation of citizenship or nationality pursuant to paragraph "d" or "e."

**75.11(3) Deeming of sponsor's income and resources.**

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor's spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien's household as described in 441—75.13(249A) less the following deductions:

(1) For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8)"b" and a \$1,500 resource deduction.

(2) For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

*b.* An indigent alien is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

*c.* A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

*d.* Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the Immigration and Nationality Act.

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under age 21.

(5) For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.

(6) For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

**75.11(4) Eligibility for payment of emergency medical services.** Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

*a.* The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

*b.* The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09; ARC 8642B, IAB 4/7/10, effective 6/1/10; ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11]

**441—75.12(249A) Inmates of public institutions.** A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" are defined by 42 CFR Section 435.1010 as amended to August 25, 2011.

**75.12(1) Suspension.** Medical assistance shall be suspended, rather than canceled, for the first 12 continuous calendar months that a person is an inmate of a public institution if all of the following conditions are met:

*a.* The department is notified of the person's entry into the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person entered the institution;

or

(2) Other verified notice received by the department.

*b.* The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

*c.* On the date of entry into the public institution, the person was a Medicaid member.

*d.* The person is eligible for medical assistance as an individual except for institutional status.

**75.12(2) Coverage during suspension.** While medical assistance is suspended, payment will be made only for services received while the person is not an inmate of a public institution.

**75.12(3) Reinstatement.** The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

*a.* The department is notified of the person's release from the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person was released from the institution; or

(2) Other verified notice received by the department.

*b.* All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[ARC 9957B, IAB 1/11/12, effective 1/1/12]

**441—75.13(249A) Categorical relatedness.**

**75.13(1) FMAP-related Medicaid eligibility.** Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

**75.13(2) SSI-related Medicaid.** Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

*a. SSI policy reference.* The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

*b. Income considered.* For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

*c. Trust contributions.* Income that a person contributes to a trust as specified at 75.24(3)“b” shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

*d. Conditional eligibility.* For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

*e. Valuation of life estates and remainder interests.* In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

**75.13(3)** *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

**441—75.14(249A) Establishing paternity and obtaining support.**

**75.14(1)** As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

*a.* The adult applicant or member shall cooperate in the following:

- (1) Identifying and locating the parent of the child for whom Medicaid is requested.
- (2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.
- (3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.
- (4) Rescinded IAB 2/3/93, effective 4/1/93.

*b.* Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

*c.* Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

*d.* Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

*e.* The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

**75.14(2)** Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

**75.14(3)** Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

**75.14(4)** Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

**75.14(5)** Rescinded IAB 6/2/10, effective 8/1/10.

**75.14(6)** Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule

75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

**75.14(7)** Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

**75.14(8)** Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

*a.* The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

*b.* The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

*c.* Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

*d.* When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

**75.14(9)** Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

*a.* Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

*b.* The initial notice advising of the right to refuse to cooperate for good cause shall:

- (1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

*c.* When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

*d.* The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

**75.14(10)** Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

*a.* The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

*b.* The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

*c.* When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

*d.* The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

*e.* Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

*f.* The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

*g.* Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

*h.* The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

**75.14(11)** Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

*a.* A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

*b.* When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or member that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

*c.* When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

- (1) Advise the applicant or member how to obtain the necessary documents, and
- (2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

*d.* When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

- (1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.
- (2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.
- (3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

*e.* The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

*f.* When it conducts an investigation of a good cause claim, the income maintenance unit shall:

- (1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.
- (2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

**75.14(12)** Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

*a.* The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

*b.* The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

*c.* When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.  
[ARC 8785B, IAB 6/2/10, effective 8/1/10]

**441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity.** Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

**75.15(1)** The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

**75.15(2)** Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

- a.* The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

**441—75.16(249A) Client participation in payment for medical institution care.** Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

**75.16(1) Income considered in determining client participation.** The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

- (1) The client has a parent or child at home.
- (2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. *Married couples.*

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. *State supplementary assistance recipients.* The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. *Foster care recipients.* The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. *Clients receiving a VA pension.* The amount of \$90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

- (1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or
- (2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

**75.16(2) Allowable deductions from income.** In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. *Ongoing personal needs allowance.* All clients shall retain \$50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed \$10 per month except with court approval.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. *Personal needs in the month of entry.*

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

*c. Personal needs in the month of discharge.* The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

*d. Maintenance needs of spouse and other dependents.*

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

*e. Maintenance needs of children (without spouse).* When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

*f. Client's medical expenses.* A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.  
[ARC 8444B, IAB 1/13/10, effective 3/1/10]

**441—75.17(249A) Verification of pregnancy.** For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

**75.17(1) Multiple pregnancy.** If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

**75.17(2) Cost of examination.** When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

**441—75.18(249A) Continuous eligibility for pregnant women.** A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

**441—75.19(249A) Continuous eligibility for children.** A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

**75.19(1) Exceptions to coverage.** This rule does not apply to the following children:

*a.* Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

*b.* Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

*c.* Children whose medical assistance is state-funded only.

*d.* Children who are eligible only in a retroactive month.

*e.* Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2)"c."

**75.19(2) Duration of coverage.** Coverage under this rule shall extend through the earliest of the following months:

*a.* The month of the household's annual eligibility review;

*b.* The month when the child reaches the age of 19; or

*c.* The month when the child moves out of Iowa.

**75.19(3) Assignment of review date.** Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[ARC 8786B, IAB 6/2/10, effective 6/1/10]

**441—75.20(249A) Disability requirements for SSI-related Medicaid.**

**75.20(1) *Applicants receiving federal benefits.*** An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

**75.20(2) *Applicants not receiving federal benefits.*** When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

*a.* A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

*b.* When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

*c.* When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

**75.20(3) *Time frames for decisions.*** Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

**75.20(4) *Reviews of disability.*** In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

**75.20(5) *Members whose disability was determined by the department.*** When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

**75.20(6) Disability redeterminations for members who attain age 18.** If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

- a. Using the standards applicable to persons who are 18 years of age or older, and
- b. Regardless of whether a review of the member's disability would otherwise be due.

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

[ARC 9044B, IAB 9/8/10, effective 11/1/10]

**441—75.21(249A) Health insurance premium payment (HIPP) program.** Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

**75.21(1) Individual health plans.** Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

- a. A household member is currently enrolled in the plan; and
- b. The health plan is cost-effective as defined in subrule 75.21(2).

**75.21(2) Cost-effectiveness.** Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

- a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.
- b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.
- c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.
- d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

- e. Annual administrative expenditures of \$50 per Medicaid member covered under the health plan.
- f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least \$5 per month per household.

**75.21(3) Coverage of non-Medicaid-eligible family members.**

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

*b.* When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

**75.21(4) *Exceptions to payment.*** Premiums shall not be paid for health insurance plans under any of the following circumstances:

*a.* The insurance plan is that of an absent parent.  
*b.* The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).

*c.* The insurance plan is a school plan offered on basis of attendance or enrollment at the school.  
*d.* The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

*e.* The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

*f.* The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

*g.* The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34). Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

*h.* Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

*i.* Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

*j.* The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

*k.* The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

*l.* The health plan pays secondary to another plan.

*m.* The only Medicaid members covered by the health plan are currently in foster care.

*n.* All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

**75.21(5) *Duplicate policies.*** When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

**75.21(6) *Discontinuation of premium payments.***

*a.* When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

*b.* When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be

cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

*c.* If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

*d.* If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

*e.* If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

**75.21(7) *Effective date of premium payment.*** The effective date of premium payments for a cost-effective health plan shall be determined as follows:

*a.* Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

*b.* If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

*c.* If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

*d.* In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

*e.* The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

*f.* The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

**75.21(8) *Method of premium payment.*** Payments of premiums will be made directly to the insurance carrier except as follows:

*a.* The department may arrange for payment to an employer in order to circumvent a payroll deduction.

*b.* When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

*c.* When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

*d.* Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

*e.* Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

**75.21(9) *Payment of claims.*** Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

**75.21(10) *Reviews of cost-effectiveness and eligibility.*** Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

b. For individual health plans, the client shall complete HIPP Private Policy Review, Form 470-3017, for the review.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment.

d. Redeterminations shall be completed whenever:

- (1) A premium rate, deductible, or coinsurance changes,
- (2) A person covered under the policy loses full Medicaid eligibility,
- (3) Changes in employment or hours of employment affect the availability of health insurance,
- (4) The insurance carrier changes,
- (5) The policyholder leaves the Medicaid home, or
- (6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)“a,” shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

**75.21(11) Time frames for determining cost-effectiveness.** The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

**75.21(12) Notices.**

a. An adequate notice shall be provided to the household under the following circumstances:

- (1) To inform the household of the initial decision on cost-effectiveness and premium payment.
- (2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.
- (3) The health plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

- (1) The department has determined the health plan is no longer cost-effective, or
- (2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

**75.21(13) Rate refund.** The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

**75.21(14) Reinstatement of eligibility.**

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

**75.21(15) Amount of premium paid.**

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(2) and 75.21(3).

**75.21(16) Reporting changes.** Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 1447C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—75.22(249A) AIDS/HIV health insurance premium payment program.** For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

**75.22(1) Conditions of eligibility.** The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify

that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

*e.* Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

*f.* Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

- (1) Unobligated cash.
- (2) Bank accounts.
- (3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

*g.* The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

**75.22(2) Application process.**

*a. Application.* Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

*b. Time limit for decision.* Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

*c. Eligible on the day of decision.* No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

*d. Waiting list.* After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

**75.22(3) Presumed eligibility** The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

*a.* The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

*b.* The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

*c.* It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

**75.22(4) Family coverage.** When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

**75.22(5) Method of premium payment.** Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

**75.22(6) Effective date of premium payment.** Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

**75.22(7) Reviews.** The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

**75.22(8) Termination of assistance.** Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

- a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).
- b. The insurance coverage is no longer available.
- c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.
- d. Funding appropriated for the program is exhausted.
- e. The person with AIDS or an HIV-related illness dies.
- f. The person fails to provide requested information necessary to establish continued eligibility for the program.

**75.22(9) Notices.**

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

- (1) To inform the applicant of the initial decision regarding eligibility to participate in the program.
- (2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).
- (3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.
- (4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.
- (5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

**75.22(10) Confidentiality.** The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

**441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993.** In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

**75.23(1) *Ineligibility for services.*** When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

*a. Institutionalized individual.* When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

*b. Noninstitutionalized individual.* When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

*c. Client participation after period of ineligibility.* Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

**75.23(2) *Look-back date.***

*a. Transfer before February 8, 2006.* For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

*b. Transfer on or after February 8, 2006.* For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

**75.23(3) *Period of ineligibility.*** The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2015, through June 30, 2016, this average statewide cost shall be \$5,407.24 per month or \$177.87 per day.

**75.23(4) *Reduction of period of ineligibility.*** The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

**75.23(5) *Exceptions.*** An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

*a.* The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

*b.* The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

*c.* A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

*d.* The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.

3. A vehicle required by the client for transportation.

4. Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

**75.23(6) *Assets held in common.*** In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

**75.23(7) *Transfer by spouse.*** In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

**75.23(8) *Definitions.*** In this rule the following definitions apply:

*"Assets"* shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

*"Income"* shall be defined by 42 U.S.C. Section 1382a.

*"Institutionalized individual"* shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

*"Resources"* shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

*"Transfer or disposal of assets"* means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) "b"(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) "c");
5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) "d");

or

6. Transferring or disclaiming the right to income not yet received.

**75.23(9) *Purchase of annuities.*** Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

*a.* The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9) "b" and also meets the condition described in paragraph 75.23(9) "c."

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or

3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

**75.23(10) Purchase of promissory notes, loans, or mortgages.**

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9) "a" were met.

**75.23(11) Purchase of life estates.**

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

*b.* Funds used to purchase a life estate in another individual's home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

- (1) The life estate was purchased before February 8, 2006; or
- (2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.  
 [ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9404B, IAB 3/9/11, effective 5/1/11; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15]

**441—75.24(249A) Treatment of trusts established after August 10, 1993.** For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

**75.24(1) Establishment of trust.**

*a.* For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

*b.* The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

*c.* In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

*d.* This rule shall apply without regard to:

- (1) The purposes for which a trust is established.
- (2) Whether the trustees have or exercise any discretion under the trust.
- (3) Any restrictions on when or whether distribution may be made for the trust.
- (4) Any restriction on the use of distributions from the trust.

*e.* The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

**75.24(2) Treatment of revocable and irrevocable trusts.**

*a.* In the case of a revocable trust:

- (1) The principal of the trust shall be considered an available resource.
- (2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

*b.* In the case of an irrevocable trust:

- (1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

**75.24(3) Exceptions.** This rule shall not apply to any of the following trusts:

*a.* A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

*b.* A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2015, to June 30, 2016, shall be as follows:

- (1) The average statewide charge to a private-pay resident of a nursing facility is \$4,952 per month.
- (2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is \$27,388 per month.
- (3) The average statewide charge to a resident of a mental health institute is \$24,083 per month.
- (4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$6,556 per month.
- (5) The average statewide charge to a home- and community-based waiver applicant or member shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

*c.* A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

- (1) The trust is established and managed by a nonprofit association.
- (2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- (3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.
- (4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0822C, IAB 7/10/13, effective 7/1/13; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 1483C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15]

**441—75.25(249A) Definitions.** Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“*Aged*” shall mean a person 65 years of age or older.

“*Applicant*” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“*Blind*” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“*Break in assistance*” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“*Central office*” shall mean the state administrative office of the department of human services.

“*Certification period*” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“*Client*” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“*CMAP-related medically needy*” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“*Community spouse*” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Conditionally eligible*” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“*Coverage group*” shall mean a group of persons who meet certain common eligibility requirements.

“*Department*” shall mean the Iowa department of human services.

“*Disabled*” shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

“*FMAP-related medically needy*” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“*Health insurance*” shall mean protection which provides payment of benefits for covered sickness or injury.

“*Incurred medical expenses*” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“*Institutionalized person*” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“*Institutionalized spouse*” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Local office*” shall mean the county office of the department of human services or the mental health institute or hospital school.

“*Medically needy income level (MNIL)*” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“*Member*” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“*Necessary medical and remedial services*” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

“*Noncovered Medicaid services*” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

“*Nursing facility services*” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“*Obligated medical expense*” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“*Ongoing eligibility*” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“*Pay and chase*” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“*Payee*” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“*Recertification*” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“*Recipient*” shall mean a person who is receiving assistance including receiving assistance for another person.

“*Responsible relative*” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“*Retroactive certification period*” for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“*Retroactive period*” shall mean the three calendar months immediately preceding the month in which an application is filed.

“*Spenddown*” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“*SSI-related*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“*SSI-related medically needy*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“*Supply*” shall mean the requested information is received by the department by the specified due date.

“*Transfer of assets*” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

“*Unborn child*” shall include an unborn child during the entire term of pregnancy.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—75.26(249A) References to the family investment program.** Rescinded IAB 10/8/97, effective 12/1/97.

**441—75.27(249A) AIDS/HIV settlement payments.** The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

**75.27(1) Class settlement payments.** Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

**75.27(2) Other settlement payments.** Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—75.28(249A) Recovery.**

**75.28(1) Definitions.**

*“Administrative overpayment”* means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

*“Agency error”* means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

*“Client”* means a current or former Medicaid member.

*“Client error”* means medical assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. “Client error” also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report as defined in rule 441—76.15(249A).

*“Department”* means the department of human services.

*“Premiums paid for medical assistance”* means monthly premiums assessed to a member or household for Medicaid, IowaCare or the Iowa Health and Wellness Plan coverage.

**75.28(2) Amount subject to recovery.** The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

**75.28(3) Notification.** All clients shall be promptly notified on Form 470-2891, Notice of Medical Assistance Overpayment, when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

*a.* Notification of incorrect expenditures shall include:

- (1) For whom assistance was paid;
- (2) The period during which assistance was incorrectly paid;
- (3) The amount of assistance subject to recovery; and
- (4) The reason for the incorrect expenditure.

*b.* Notification of unpaid premiums shall include:

- (1) The amount of the premium; and
- (2) The month covered by the medical assistance premium.

**75.28(4) Source of recovery.** Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

**75.28(5) *Repayment.*** The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for persons with an intellectual disability, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

**75.28(6) *Appeals.*** The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

**75.28(7) *Estate recovery.*** Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, the estate of the member's surviving spouse, or the estate of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.53(2) "d." The classification of the debt is defined at Iowa Code section 633.425(7).

*a. Definitions.*

"*Capitated payment/rate*" means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

"*Estate.*" For the purpose of this subrule, the "estate" of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

"*Managed care organization*" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

*b. Debt due for member 55 years of age or older.* Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

*c. Debt due for member under the age of 55 in a medical institution.*

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994, when the member:

1. Is under the age of 55; and
2. Is a resident of a nursing facility, an intermediate care facility for persons with an intellectual disability, or a mental health institute; and

3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

*d. Request for a determination of ability to return home.* Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

*e. Determination of ability to return home.* When the member or someone acting on the member's behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

*f. Debt collection.*

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

*g. Waiving the collection of the debt.*

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed \$10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" shall be defined as being under the family investment program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 249A.53(2).

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

*h. Amount waived.* If collection of all or part of a debt is waived pursuant to paragraph 75.28(7) “g,” to the extent that the person received the member’s estate, the amount waived shall be a debt due from the following:

- (1) The estate of the member’s surviving spouse, upon the death of the spouse.
- (2) The estate of the member’s surviving child who is blind or has a disability, upon the death of the child.
- (3) A surviving child who was under 21 years of age at the time of the member’s death, when the child reaches the age of 21.
- (4) The estate of a surviving child who was under 21 years of age at the time of the member’s death, if the child dies before reaching the age of 21.
- (5) The hardship waiver recipient, when the hardship no longer exists.
- (6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

*i. Impact of asset disregard on debt due.* The estate of a member who is eligible for medical assistance under subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member’s behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid on behalf of the member before these conditions shall be recovered from the estate, regardless of the member’s having purchased precertified or approved insurance.

*j. Interest on debt.* Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child’s reaching the age of 21.

*k. Reimbursement to county.* If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department shall reimburse the county on a proportionate basis.

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—75.29(249A) Investigation by quality control or the department of inspections and appeals.** An applicant or member shall cooperate with the department when the applicant’s or member’s case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of medical assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person’s eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

**441—75.30(249A) Member lock-in.** Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

**441—75.31 to 75.49** Reserved.

DIVISION II  
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO  
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

**441—75.50(249A) Definitions.** The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“*Applicant*” shall mean a person who is requesting assistance on the person’s own behalf or on behalf of another person, including recertification under the medically needy program. This also includes

parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

*“Application period”* means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

*“Assistance unit”* includes any person whose income is considered when determining eligibility.

*“Bona fide offer”* means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

*“Central office”* shall mean the state administrative office of the department of human services.

*“Change in income”* means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

*“Change in work expenses”* means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

*“Department”* shall mean the Iowa department of human services.

*“Dependent”* means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

*“Dependent child”* or *“dependent children”* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

*“Income in-kind”* is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

*“Initial two months”* means the first two consecutive months for which eligibility is granted.

*“Medical institution,”* when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

*“Needy specified relative”* means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

*“Nonrecurring lump sum unearned income”* means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

*“Parent”* means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

*“Prospective budgeting”* means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

*“Recipient”* means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

*“Schedule of needs”* means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

*“Stepparent”* means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent by ceremonial or common-law marriage.

*“Unborn child”* shall include an unborn child during the entire term of the pregnancy.

“*Uniformed service*” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

**441—75.51(249A) Reinstatement of eligibility.** Rescinded IAB 2/10/10, effective 3/1/10.

**441—75.52(249A) Continuing eligibility.**

**75.52(1) Reviews.** Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

**75.52(2) Additional reviews.** A redetermination of specific eligibility factors shall be made when:

*a.* The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

*b.* A change in the member’s circumstances comes to the attention of a staff member.

**75.52(3) Forms.**

*a.* Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

*b.* The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

*c.* The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

**75.52(4) Client responsibilities.** For the purposes of this subrule, “clients” shall include persons who received assistance subject to recoupment because the persons were ineligible.

*a.* The client shall cooperate by giving complete and accurate information needed to establish eligibility.

*b.* The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) “*f*” and 75.57(2) “*l*.”

*c.* The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

- (1) Income from all sources, including any change in care expenses.
- (2) Resources.
- (3) Members of the household.
- (4) School attendance.
- (5) A stepparent recovering from an incapacity.
- (6) Change of mailing or living address.
- (7) Payment of child support.
- (8) Receipt of a social security number.

- (9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8) “b.”
- (10) Health insurance premiums or coverage.
- d. All clients shall timely report any change in the following circumstances at any time:
  - (1) Members of the household.
  - (2) Change of mailing or living address.
  - (3) Sources of income.
  - (4) Health insurance premiums or coverage.
- e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.
- f. A report shall be considered timely when made within ten days from the date:
  - (1) A person enters or leaves the household.
  - (2) The mailing or living address changes.
  - (3) A source of income changes.
  - (4) A health insurance premium or coverage change is effective.
  - (5) Of any change in income.
  - (6) Of any change in care expenses.
- g. When a change is not reported as required in paragraphs 75.52(4) “c” through “e,” any excess Medicaid paid shall be subject to recovery.
- h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4) “c” through “e.”

**75.52(5) Effective date.** After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8500B, IAB 2/10/10, effective 3/1/10]

**441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups.** Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

**75.53(1) Definition of resident.** A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

**75.53(2) Retention of residence.** Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

**75.53(3) Suitability of home.** The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

**75.53(4) *Absence from the home.***

*a.* An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph “*b.*”

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. “Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

*b.* The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician’s statement. Failure to return within one year from the date of entry into the medical institution will result in the individual’s needs being removed from the eligible group.

(2) A child is out of the home to secure education or training as defined in paragraph 75.54(1) “*b*” as long as the child remains a dependent.

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, “education or training” means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

(4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4) “*b*”(1) through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual’s needs being removed from the eligible group.

[ARC 0579C, IAB 2/6/13, effective 4/1/13]

**441—75.54(249A) Eligibility factors specific to child.**

**75.54(1) *Age.*** Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

*a.* A child is eligible for the entire month in which the child’s eighteenth birthday occurs, unless the birthday falls on the first day of the month.

*b.* Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child’s education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

**75.54(2) *Residing with a relative.*** The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

*a.* Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

*b.* Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

**75.54(3)** *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

**75.54(4)** *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

**441—75.55(249A) Eligibility factors specific to specified relatives.**

**75.55(1)** *Specified relationship.*

*a.* A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

*b.* A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

**75.55(2)** *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

*a.* When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

*b.* When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

**441—75.56(249A) Resources.**

**75.56(1)** *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

*a.* A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined

purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) "n" or "o," the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$3,000 shall be counted toward the resource limit in paragraph 75.56(1) "e." When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the \$5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9) "c" reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph "e."

o. Nonhomestead property that produces income consistent with the property's fair market value.

**75.56(2) Persons considered.**

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

**75.56(3) Homestead defined.** The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

**75.56(4) Liquidation.** When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) "d" and 75.57(7) "ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

**75.56(5) Net market value defined.** Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

**75.56(6) Availability.**

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

**75.56(7) Damage judgments and insurance settlements.**

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month

the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

*b.* Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

**75.56(8) Conservatorships.**

*a.* Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

*b.* Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1) “*e*” and 75.24(2) “*b*.”

**75.56(9) Not considered a resource.** Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

**441—75.57(249A) Income.** When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month’s needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1) “*e*,” 75.57(6) “*u*,” and 75.57(7) “*o*.” Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

**75.57(1) Unearned income.** Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

*a.* Social security income is the amount of the entitlement before withholding of a Medicare premium.

*b.* Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

*c.* Rescinded IAB 2/11/98, effective 2/1/98.

*d.* When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

*e.* Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

*f.* The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

**75.57(2) Earned income.** Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing

the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

*a.* Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

*b.* Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)“*b*” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“*c*” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed \$175 per month, or \$200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual’s employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

*c.* Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)“*a*” and “*b*” and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)“*a*”(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

*d.* Rescinded IAB 6/30/99, effective 9/1/99.

*e.* A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person’s own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

*f.* The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

*g.* When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

*h.* In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) \$41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or \$41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

*i.* Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."

*j.* In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

*k.* Rescinded IAB 6/30/99, effective 9/1/99.

*l.* The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

**75.57(3) Shared living arrangements.** When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

**75.57(4) Diversion of income.**

*a.* Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b."

*b.* Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

**75.57(5) Income of unmarried specified relatives under the age of 19.**

*a.* Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

*b.* Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

**75.57(6) Exempt as income and resources.** The following shall be exempt as income and resources:

*a.* Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

*b.* The value of the food assistance program benefit.

*c.* The value of the United States Department of Agriculture donated foods (surplus commodities).

*d.* The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

*e.* Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

- f.* Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.
- g.* Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.
- h.* Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.
- i.* Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.
- j.* Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.
- k.* Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.
- l.* Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
- m.* The income of a supplemental security income recipient.
- n.* Income of an ineligible child.
- o.* Income in-kind.
- p.* Family support subsidy program payments.
- q.* Grants obtained and used under conditions that preclude their use for current living costs.
- r.* All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.
- s.* Subsidized guardianship program payments.
- t.* Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
- u.* The first \$50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.
- v.* Bona fide loans. Evidence of a bona fide loan may include any of the following:
- (1) The loan is obtained from an institution or person engaged in the business of making loans.
  - (2) There is a written agreement to repay the money within a specified time.
  - (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
- w.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
- x.* The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
- y.* Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
- z.* Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

*aa.* Payments received from the Radiation Exposure Compensation Act.

*ab.* Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2) "a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

**75.57(7) Exempt as income.** The following are exempt as income.

- a.* Reimbursements from a third party.
- b.* Reimbursement from the employer for a job-related expense.
- c.* The following nonrecurring lump sum payments:
  - (1) Income tax refund.
  - (2) Retroactive supplemental security income benefits.
  - (3) Settlements for the payment of medical expenses.
  - (4) Refunds of security deposits on rental property or utilities.
  - (5) That part of a lump sum received and expended for funeral and burial expenses.
  - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d.* Payments received by the family for providing foster care when the family is operating a licensed foster home.
- e.* A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.
- f.* Federal or state earned income tax credit.
- g.* Supplementation from county funds, providing:
  - (1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or
  - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- h.* Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- i.* A retroactive corrective family investment program (FIP) payment.
- j.* The training allowance issued by the division of vocational rehabilitation, department of education.
- k.* Payments from the PROMISE JOBS program.
- l.* The training allowance issued by the department for the blind.
- m.* Payments from passengers in a car pool.
- n.* Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- o.* Rescinded IAB 10/4/00, effective 10/1/00.
- p.* Rescinded IAB 10/4/00, effective 10/1/00.
- q.* Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
- r.* Rescinded IAB 10/4/00, effective 10/1/00.
- s.* Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

*t.* Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

*u.* Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)“*b*”(1) and (2). The exemption applies through the entire month of the person’s twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

*v.* Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)“*c*” effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

*w.* Incentive payments received from participation in the adolescent pregnancy prevention programs.

*x.* Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

*y.* Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

*z.* Interest and dividend income.

*aa.* Rescinded IAB 10/4/00, effective 10/1/00.

*ab.* Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

*ac.* Income that an individual contributes to a trust as specified at paragraph 75.24(3)“*b*” shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

*ad.* Benefits paid to the eligible household under the family investment program (FIP).

*ae.* Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

*af.* Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than \$1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the \$1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than \$1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

*ag.* Payments from property sold under an installment contract as specified in paragraphs 75.56(4) "b" and 75.57(1) "d."

*ah.* All census earnings received by temporary workers from the Bureau of the Census.

*ai.* Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

**75.57(8)** *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

*a. Treatment of income in excluded parent cases.* A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) "a," "b," and "c," and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

*b. Treatment of income in stepparent cases.* The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) "b"(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) "b"(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) "b"(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) "a"(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5)

shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)“f.”

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FMAP-related Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent’s dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

*c. Treatment of income in underage parent cases.* In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent’s own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)“b”(1) through (7). Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the self-supporting parent’s ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)“b”(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)“b”(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse’s ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

**75.57(9) Budgeting process.**

*a.* Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified

at paragraph 75.57(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)“d” and “e” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)“c” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

*b.* Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)“i.”

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

*c.* Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)“b” and “c,” shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers’ compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any

income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or  
2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

*d.* The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2) “*b*,” shall be dropped.

*e.* In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

*f.* Rescinded IAB 10/4/00, effective 10/1/00.

*g.* Rescinded IAB 2/11/98, effective 2/1/98.

*h.* Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

*i.* Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual’s annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income

shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

**75.57(10)** *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

**75.57(11)** *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8556B**, IAB 3/10/10, effective 2/10/10; **ARC 9043B**, IAB 9/8/10, effective 11/1/10]

#### **441—75.58(249A) Need standards.**

**75.58(1)** *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

*a.* The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

*b.* The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent

children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

**75.58(2) Schedule of needs.** The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

#### SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

#### CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

- a. The definitions of the basic need components are as follows:
- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
  - (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

**441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.**

**75.59(1) Exclusions from the eligible group.** In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

**75.59(2) Needs, income, and resource exclusions.** The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

**75.59(3) Medicaid entitlement.** Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

**75.59(4) Situations where parent's needs are excluded.** In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) "a," "b," and "c."

**75.59(5) Situations where child's needs, income, and resources are excluded.** In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

**441—75.60(249A) Pending SSI approval.** When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

**441—75.61 to 75.69** Reserved.

DIVISION III  
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

**441—75.70(249A) Financial eligibility based on modified adjusted gross income (MAGI).** Notwithstanding any other provision of this chapter, effective January 1, 2014, financial eligibility for medical assistance shall be determined using "modified adjusted gross income" (MAGI) and "household income" pursuant to 42 U.S.C. § 1396a(e)(14), to the extent required by that section as a condition of federal funding under Title XIX of the Social Security Act. For this purpose, financial eligibility for medical assistance includes any applicable purpose for which a determination of income is required, including the imposition of any premiums or cost sharing. From January 1, 2014, through June 30, 2014, subject to a waiver of the requirements of 42 U.S.C. § 1396a(e)(14) by the federal Centers for Medicare and Medicaid Services, use of MAGI and "household income" shall not be considered to be required by that section for persons otherwise eligible for family planning services under subrule 75.1(41).

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1212C, IAB 12/11/13, effective 1/1/14; ARC 1356C, IAB 3/5/14, effective 4/9/14]

**441—75.71(249A) Income limits.** Notwithstanding any other provision of this chapter, effective January 1, 2014, the following income limits apply to the following coverage groups, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Family Medical Assistance Program and Child Medical Assistance Program	441—subrule 75.1(14) and 441—subrule 75.1(15); 42 CFR Part 435.110; Title XIX of the Social Security Act, Section 1931	1	\$447
		2	\$716
		3	\$872
		4	\$1,033
		5	\$1,177
		6	\$1,330
		7	\$1,481
		8	\$1,633
		9	\$1,784
		10	\$1,950
			over 10
Mothers and Children, for pregnant women and for infants under one year of age	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		375% of the federal poverty level for the household
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		167% of the federal poverty level for the household
Medicaid for Independent Young Adults	441—subrule 75.1(42); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)		254% of the federal poverty level for the household

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1212C, IAB 12/11/13, effective 1/1/14; ARC 1356C, IAB 3/5/14, effective 4/9/14]

These rules are intended to implement Iowa Code section 249A.4.

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◇ Two or more ARCs

<sup>1</sup> 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.

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

[Prior to 7/1/83, Social Services[770] Ch 77]

[Prior to 2/11/87, Human Services[498]]

**441—77.1(249A) Physicians.** All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

**441—77.2(249A) Retail pharmacies.** Retail pharmacies are eligible to participate if they meet the requirements of this rule.

**77.2(1) *Licensure.*** Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

**77.2(2) *Survey participation.*** As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

*a.* A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

*b.* A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

*c.* Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

**441—77.3(249A) Hospitals.**

**77.3(1) *Qualifications.*** All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

**77.3(2) *Referral to health home services provider.*** As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

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

[ARC 0198C, IAB 7/11/12, effective 7/1/12]

**441—77.4(249A) Dentists.** All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

**441—77.5(249A) Podiatrists.** All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

**441—77.6(249A) Optometrists.** All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

**441—77.7(249A) Opticians.** All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

**441—77.8(249A) Chiropractors.** All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

**441—77.9(249A) Home health agencies.** Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

**77.9(1) Definitions.**

“*Assets*” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

“*Rider*” means a notice issued by a surety that a change in the bond has occurred or will occur.

“*Uncollected overpayment*” means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

**77.9(2) Parties to surety bonds.** The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety’s name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company’s liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

**77.9(3) Surety company obligations.** The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

**77.9(4) Surety bond requirements.** Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. *Effective dates and submission dates.*

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

*b. Amount of bond.* Bonds for any period shall be in the amount of \$50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of \$50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

*c. Other requirements.* Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

**77.9(5)** *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

**77.9(6)** *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

**441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies.** All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

**441—77.11(249A) Ambulance service.** Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

**441—77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. Iowa Administrative Code 441—Chapter 24, "Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities."

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.13(249A) Hearing aid dispensers.** Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

**441—77.14(249A) Audiologists.** Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

**441—77.15(249A) Community mental health centers.** Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

**441—77.16(249A) Screening centers.** Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

**441—77.17(249A) Physical therapists.** Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

**441—77.18(249A) Orthopedic shoe dealers and repair shops.** Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

**441—77.19(249A) Rehabilitation agencies.** Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

**441—77.20(249A) Independent laboratories.** Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

**441—77.21(249A) Rural health clinics.** Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

**441—77.22(249A) Psychologists.** All psychologists licensed to practice in the state of Iowa and meeting the current credentialing requirements of the National Register of Health Service Psychologists are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the current credentialing requirements of the National Register of Health Service Psychologists.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

[ARC 2165C, IAB 9/30/15, effective 12/1/15]

**441—77.23(249A) Maternal health centers.** A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

**441—77.24(249A) Ambulatory surgical centers.** Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

**441—77.25(249A) Home- and community-based habilitation services.** To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

**77.25(1) Definitions.**

“*Guardian*” means a guardian appointed in probate or juvenile court.

“*Major incident*” means an occurrence involving a member during service provision 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 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

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

“*Minor incident*” means an occurrence involving a member during service provision that is not a major incident and 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.

**77.25(2) Organization and staff.**

*a.* The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

*b.* The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

*c.* A person providing direct care shall be at least 16 years of age.

*d.* A person providing direct care shall not be an immediate family member of the member.

**77.25(3) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

*a. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the 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.

*b. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member's supervisor.

2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager.

(2) By the end of the next calendar 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 about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.

2. The date and time 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 members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

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

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

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

*c. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.25(4) Restraint, restriction, and behavioral intervention.** The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

*a.* The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

*b.* Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

*c.* Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

*d.* Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

*e.* Corporal punishment and verbal or physical abuse are prohibited.

**77.25(5) Case management.** The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

**77.25(6) Day habilitation.** The following providers may provide day habilitation:

*a.* An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

*b.* An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph "*a,*" "*d,*" "*g,*" or "*h.*"

*c.* An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

*d.* An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

*e.* An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

*f.* An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

*g.* An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

*h.* An agency that is accredited by the International Center for Clubhouse Development.

*i.* An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

**77.25(7) Home-based habilitation.** The following agencies may provide home-based habilitation services:

*a.* An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

*b.* An agency that is accredited under 441—Chapter 24 to provide supported community living services.

*c.* An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

*d.* An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

*e.* An agency that is accredited by the Council on Accreditation of Services for Families and Children.

*f.* An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

**77.25(8) Prevocational habilitation.** The following providers may provide prevocational services:

*a.* An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

*b.* An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

*c.* An agency that is accredited by the International Center for Clubhouse Development.

*d.* An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

**77.25(9) Supported employment habilitation.** The following agencies may provide supported employment services:

*a.* An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

*b.* An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

*c.* An agency that is accredited by the Council on Accreditation of Services for Families and Children.

*d.* An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

*e.* An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

*f.* An agency that is accredited by the International Center for Clubhouse Development.

**77.25(10) Provider enrollment.** Rescinded IAB 1/6/16, effective 1/1/16.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.26(249A) Behavioral health services.** The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

**77.26(1) Licensed marital and family therapists (LMFT).** Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

**77.26(2) Licensed independent social workers (LISW).** Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

**77.26(3) Licensed master social workers (LMSW).**

*a.* A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

*b.* A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

**77.26(4) Licensed mental health counselors (LMC).** Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible

to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

**77.26(5) Certified alcohol and drug counselors.** Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

**441—77.27(249A) Birth centers.** Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

**441—77.28(249A) Area education agencies.** An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

**77.28(1)** Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

**77.28(2)** Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

**77.28(3)** Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

**77.28(4)** Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

*a.* Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(3);

*b.* Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

*c.* Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

*d.* Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

*e.* Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

**77.28(5)** Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

**77.28(6)** Personnel providing vision services shall be:

*a.* Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

*b.* Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

*c.* Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

[ARC 1807C, IAB 1/7/15, effective 3/1/15]

**441—77.29(249A) Case management provider organizations.** Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

**77.29(1) Standards in 441—Chapter 24.** Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case

management services to persons with mental retardation, developmental disabilities or chronic mental illness.

**77.29(2) Standards in 441—Chapter 186.** Rescinded IAB 10/12/05, effective 10/1/05.

**441—77.30(249A) HCBS health and disability waiver service providers.** HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

**77.30(1) Homemaker providers.** Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.30(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.30(3) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.30(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.30(5) Respite care providers.**

- a. The following agencies may provide respite services:
  - (1) Home health agencies that are certified to participate in the Medicare program.
  - (2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
  - (3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
  - (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
  - (5) Camps certified by the American Camping Association.
  - (6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
  - (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
  - (8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
  - (9) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
  - (1) Providers shall maintain the following information that shall be updated at least annually:
    1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
    2. An emergency medical care release.
    3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
    4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.30(6) Counseling providers.** Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.30(7) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.30(8) *Interim medical monitoring and treatment providers.***

- a. The following providers may provide interim medical monitoring and treatment services:
  - (1) Home health agencies certified to participate in the Medicare program.
  - (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
- b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
  - (1) Be at least 18 years of age.
  - (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
  - (3) Not be a usual caregiver of the member.
  - (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.30(9) *Home and vehicle modification providers.*** The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.30(10) *Personal emergency response system providers.*** Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

**77.30(11) *Home-delivered meals.*** The following providers may provide home-delivered meals:

- a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.30(12) *Nutritional counseling.*** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians approved by an area agency on aging.

**77.30(13) Financial management service.** Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

- a. The financial institution shall either:

- (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

- (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

- b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

- c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

- d. The financial institution shall enroll as a Medicaid provider.

**77.30(14) Independent support brokerage.** Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

- a. The broker must be at least 18 years of age.

- b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

- c. The broker shall not provide any other paid service to the member.

- d. The broker shall not work for an individual or entity that is providing services to the member.

- e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

- f. The broker must complete independent support brokerage training approved by the department.

**77.30(15) Self-directed personal care.** Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

- a. A business providing self-directed personal care services shall:

- (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

- (2) Have current liability and workers' compensation coverage.

- b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

- c. All personnel providing self-directed personal care services shall:

- (1) Be at least 16 years of age.

- (2) Be able to communicate successfully with the member.

- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

- d. The provider of self-directed personal care services shall:

- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

- (2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(16) Individual-directed goods and services.** Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

- a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

*b.* An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

*c.* All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

*d.* The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(17) *Self-directed community supports and employment.*** Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

*a.* A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

*b.* An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

*c.* All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

*d.* The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(18) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

*a.* *Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer 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 consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and 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.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the 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 consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar 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 about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time 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 waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

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

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.31(249A) Occupational therapists.** Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

**77.31(1)** Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.31(2)** Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

**441—77.32(249A) Hospice providers.** Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

**441—77.33(249A) HCBS elderly waiver service providers.** HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

**77.33(1) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.33(2) Emergency response system providers.** Emergency response system providers must meet the following standards:

*a.* The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

*b.* The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

**77.33(3) Home health aide providers.** Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

**77.33(4) Homemaker providers.** Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.33(5) Nursing care.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.33(6) Respite care providers.**

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.33(7) *Chore providers.*** The following providers may provide chore services:

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

**77.33(8) *Home-delivered meals.*** The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.33(9) *Home and vehicle modification providers.*** The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.33(10) *Mental health outreach providers.*** Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

**77.33(11) *Transportation providers.*** The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

- c. Regional transit agencies as recognized by the Iowa department of transportation.
- d. Rescinded IAB 3/10/99, effective 5/1/99.
- e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- f. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.33(12) *Nutritional counseling.*** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians.

**77.33(13) *Assistive device providers.*** The following providers may provide assistive devices:

- a. Medicaid-enrolled medical equipment and supply dealers.
- b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

- (1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
- (2) Submit verification of current liability and workers' compensation coverage.

**77.33(14) *Senior companions.*** Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

**77.33(15) *Consumer-directed attendant care providers.*** The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
  - (1) At least 18 years of age.
  - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.33(16) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.33(17) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.33(18) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.33(19) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.33(20) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.33(21) Case management providers.** A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

- a. The case management provider shall be an agency or individual that:
  - (1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or
  - (2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
  - (3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
  - (4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or
  - (5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or
  - (6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:
    1. Meets the qualifications for case managers in 641—subrule 80.6(1); and
    2. Provides a current IDPH local public health services contract number.
- b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:
  - (1) Specific procedures to identify conflicts of interest.
  - (2) Procedures to eliminate any conflict of interest that is identified.
  - (3) Procedures for handling complaints of conflict of interest, including written documentation.
- c. If the case management provider organization subcontracts case management services to another entity:
  - (1) That entity must also meet the provider qualifications in this subrule; and
  - (2) The contractor is responsible for verification of compliance.

**77.33(22) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. *Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer 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 consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and 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.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the 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 consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar 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 about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time 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 waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.33(23) Assisted living on-call service.** Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

This rule is intended to implement Iowa Code section 249A.4.  
 [ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.34(249A) HCBS AIDS/HIV waiver service providers.** HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

**77.34(1) Counseling providers.** Counseling providers shall be:

*a.* Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

*b.* Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

*c.* Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.34(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.34(3) Homemaker providers.** Homemaker providers shall be agencies that are:

*a.* Certified as a home health agency under Medicare, or  
*b.* Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.34(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

**77.34(5) Respite care providers.**

*a.* The following agencies may provide respite services:

- (1) Home health agencies that are certified to participate in the Medicare program.
- (2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.
- (3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
- (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (5) Camps certified by the American Camping Association.
- (6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).
- (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).
- (8) Assisted living programs certified by the department of inspections and appeals.

- b.* Respite providers shall meet the following conditions:
- (1) Providers shall maintain the following information that shall be updated at least annually:
    1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
    2. An emergency medical care release.
    3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
    4. The consumer's medical issues, including allergies.
    5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
  - (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

- (3) Policies shall be developed for:
  1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
  2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
  3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
  4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

*c.* A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

*d.* Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.34(6) Home-delivered meals.** The following providers may provide home-delivered meals:

- a.* Home health aide providers meeting the standards set forth in subrule 77.34(2).
- b.* Home care providers meeting the standards set forth in subrule 77.34(3).
- c.* Hospitals enrolled as Medicaid providers.
- d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- e.* Restaurants licensed and inspected under Iowa Code chapter 137F.
- f.* Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.
- g.* Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

*h.* Medical equipment and supply dealers certified to participate in the Medicaid program.

**77.34(7) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.34(8) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
  - (1) At least 18 years of age.
  - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies which are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.93.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.34(9) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.34(10) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.34(11) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.34(12) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.34(13) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.34(14) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. *Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer 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 consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"*Minor incident*" means an occurrence involving a consumer during service provision that is not a major incident and 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.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the 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 consumer's file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar 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 about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time 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 waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.35(249A) Federally qualified health centers.** Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

**441—77.36(249A) Advanced registered nurse practitioners.** Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

**77.36(1)** Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

**77.36(2)** Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

**77.36(3)** Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

**441—77.37(249A) Home- and community-based services intellectual disability waiver service providers.** Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)“a”(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

**77.37(1) Organizational standards (Outcome 1).** Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

*a.* The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

*b.* The organization demonstrates a defined mission commensurate with consumer’s needs, desires, and abilities.

*c.* The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

- (1) Consumer rights.
- (2) Confidentiality.
- (3) Provision of consumer medication.
- (4) Identification and reporting of child and dependent adult abuse.
- (5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

- (1) Measures and assesses organizational activities and services annually.
- (2) Gathers information from consumers, family members, and staff.
- (3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

- (5) Identifies areas in need of improvement.
- (6) Develops a plan to address the areas in need of improvement.
- (7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.37(2) Rights and dignity.** Outcome-based standards for rights and dignity are as follows:

- a. (Outcome 2) Consumers are valued.
- b. (Outcome 3) Consumers live in positive environments.
- c. (Outcome 4) Consumers work in positive environments.
- d. (Outcome 5) Consumers exercise their rights and responsibilities.
- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

**77.37(3) *Contracts with consumers.*** The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

*a.* The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

*b.* Contracts shall be reviewed at least annually.

**77.37(4) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.37(5) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

**77.37(6) *Research.*** If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

**77.37(7) *Abuse reporting requirements.*** The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

**77.37(8) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

*a. Definitions.*

*“Major incident”* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer 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 consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*“Minor incident”* means an occurrence involving a consumer during service provision that is not a major incident and 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.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the 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 consumer's file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff consumer's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar 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 about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time 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 waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.37(9)** *Intake, admission, service coordination, discharge, and referral.*

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

*b.* The provider shall ensure the rights of persons applying for services.

**77.37(10)** *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

- a.* Rescinded IAB 9/1/04, effective 11/1/04.
- b.* Rescinded IAB 9/1/04, effective 11/1/04.
- c.* Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.37(11) Initial certification.** The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

**77.37(12) Period of certification.** Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the

month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*c.* The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

*d.* During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

*e.* As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

*f.* The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:  
(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e."

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.37(13) Review of providers.** Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13) "e" and 77.37(13) "f."

h. The department may conduct a site visit to verify all or part of the information submitted.

**77.37(14) Supported community living providers.**

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing

how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.
2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

*e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

*f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

- (1) Approval will not result in an overconcentration of supported community living units in a geographic area.

- (2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**77.37(15) Respite care providers.**

*a.* The following agencies may provide respite services:

- (1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

- (2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

- (3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

- (4) Home health agencies that are certified to participate in the Medicare program.

- (5) Camps certified by the American Camping Association.

- (6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

- (7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

- (8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

- (9) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.37(16) Supported employment providers.**

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

**77.37(17) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.37(18) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

**77.37(19) *Nursing providers.*** Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

**77.37(20) *Home health aide providers.*** Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

**77.37(21) *Consumer-directed attendant care providers.*** The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
  - (1) At least 18 years of age.
  - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies which are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.93.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.37(22) *Interim medical monitoring and treatment providers.***

- a. The following providers may provide interim medical monitoring and treatment services:
  - (1) Home health agencies certified to participate in the Medicare program.
  - (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
- b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
  - (1) Be at least 18 years of age.
  - (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
  - (3) Not be a usual caregiver of the member.
  - (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.
- c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.37(23) *Residential-based supported community living service providers.***

- a. The department shall contract only with public or private agencies to provide residential-based supported community living services.
- b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:
  - (1) Agencies licensed as group living foster care facilities under 441—Chapter 114.
  - (2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.

- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

*c.* As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

*d.* As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.

3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.

4. Specific service activities to be provided to achieve the objectives.

5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.

6. Date of service initiation and date of individual service plan development.

7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

*e.* The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.

2. What physical change will need to take place in the living units.

3. How children and their families will be involved in the transitioning process.

4. How this transition will affect children's social and educational environment.

*f.* Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h" and subparagraph 77.37(23) "f"(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

**77.37(24) Transportation service providers.** The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

g. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.37(25) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.37(26) Prevocational services providers.** Providers of prevocational services must be accredited by one of the following:

- a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.
- b. The Council on Quality and Leadership.

**77.37(27) Day habilitation providers.** Day habilitation services may be provided by:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph “a” or “d.”

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

**77.37(28) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.37(29) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.37(30) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.37(31) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.37(32) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4.  
 [ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.38(249A) Assertive community treatment.** Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

**77.38(1) Minimum composition.** At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

**77.38(2) Psychiatrists.** A psychiatrist on the team shall be a physician (MD or DO) who:

- a. Is licensed under 653—Chapter 9,
- b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and
- c. Has experience treating serious and persistent mental illness.

**77.38(3) Registered nurses.** A nurse on the team shall:

- a. Be licensed as a registered nurse under 655—Chapter 3, and
- b. Have experience treating persons with serious and persistent mental illness.

**77.38(4) Mental health service providers.** A mental health service provider on the team shall be:

- a. A mental health counselor or marital and family therapist who:
  - (1) Is licensed under 645—Chapter 31, and
  - (2) Has experience treating persons with serious and persistent mental illness; or
- b. A social worker who:
  - (1) Is licensed as a master or independent social worker under 645—Chapter 280, and
  - (2) Has experience treating persons with serious and persistent mental illness.

**77.38(5) Psychologists.** A psychologist on the team shall:

- a. Be licensed under 645—Chapter 240, and
- b. Have experience treating persons with serious and persistent mental illness.

**77.38(6) Substance abuse treatment professionals.** A substance abuse treatment professional on the team shall:

- a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)“i,” and
- b. Have at least three years of experience treating substance abuse.

**77.38(7) Peer specialists.** A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

**77.38(8) Community support specialists.** A community support specialist on the team shall be a person who:

- a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and
- b. Has experience supporting persons with serious and persistent mental illness.

**77.38(9) Case managers.** A case manager on the team shall be a person who:

- a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),
- b. Has experience managing care for persons with serious and persistent mental illness, and
- c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

**77.38(10) *Advanced registered nurse practitioners.*** An advanced registered nurse practitioner on the team shall:

- a. Be licensed under 655—Chapter 7,
- b. Have a mental health certification, and
- c. Have experience treating serious and persistent mental illness.

**77.38(11) *Physician assistants.*** A physician assistant on the team shall:

- a. Be licensed under 645—Chapter 326,
- b. Have experience treating persons with serious and persistent mental illness, and
- c. Practice under the supervision of a psychiatrist.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**441—77.39(249A) HCBS brain injury waiver service providers.** Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

**77.39(1) *Organizational standards (Outcome 1).*** Organizational outcome-based standards for HCBS BI providers are as follows:

- a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- b. The organization demonstrates a defined mission commensurate with consumers’ needs, desires, and abilities.
- c. The organization establishes and maintains fiscal accountability.
- d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
- e. The organization provides needed training and supports to its staff. This training includes at a minimum:

- (1) Consumer rights.
- (2) Confidentiality.

- (3) Provision of consumer medication.
- (4) Identification and reporting of child and dependent adult abuse.
- (5) Individual consumer support needs.

*f.* The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

- (1) Measures and assesses organizational activities and services annually.
- (2) Gathers information from consumers, family members, and staff.
- (3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
- (4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
- (5) Identifies areas in need of improvement.
- (6) Develops a plan to address the areas in need of improvement.
- (7) Implements the plan and documents the results.

*g.* Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

*h.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

*i.* The governing body has an active role in the administration of the agency.

*j.* The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.39(2) *Rights and dignity.*** Outcome-based standards for rights and dignity are as follows:

- a.* (Outcome 2) Consumers are valued.
- b.* (Outcome 3) Consumers live in positive environments.
- c.* (Outcome 4) Consumers work in positive environments.
- d.* (Outcome 5) Consumers exercise their rights and responsibilities.
- e.* (Outcome 6) Consumers have privacy.
- f.* (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g.* (Outcome 8) Consumers decide which personal information is shared and with whom.
- h.* (Outcome 9) Consumers make informed choices about where they work.
- i.* (Outcome 10) Consumers make informed choices on how they spend their free time.
- j.* (Outcome 11) Consumers make informed choices about where and with whom they live.
- k.* (Outcome 12) Consumers choose their daily routine.
- l.* (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m.* (Outcome 14) Consumers have a social network and varied relationships.
- n.* (Outcome 15) Consumers develop and accomplish personal goals.
- o.* (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p.* (Outcome 17) Consumers maintain good health.
- q.* (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r.* (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s.* (Outcome 20) Consumers have an impact on the services they receive.

**77.39(3) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.39(4) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the

storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

**77.39(5) Research.** If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

**77.39(6) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

*a. Definitions.*

*"Major incident"* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer 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 consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and 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.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the 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 consumer's file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. **EXCEPTION:** Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar 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 about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time 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 waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

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

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

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.39(7)** *Intake, admission, service coordination, discharge, and referral.*

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

*b.* The provider shall ensure the rights of persons applying for services.

**77.39(8)** *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

*a.* Rescinded IAB 9/1/04, effective 11/1/04.

*b.* Rescinded IAB 9/1/04, effective 11/1/04.

*c.* Rescinded IAB 9/1/04, effective 11/1/04.

*d.* The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.39(9)** *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

*a.* The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

*b.* The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

*c.* Providers applying for initial certification shall be offered technical assistance.

**77.39(10)** *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar

years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*a. Initial certification.* Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

*b. Recertification.* After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*c. The department may issue four categories of recertification:*

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits,

written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

*d.* During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. “Immediate jeopardy” refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider’s services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider’s service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider’s services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider’s inaction.

*e.* As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

*f.* The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department’s approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

*g.* The department may revoke the provider’s approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)“*d.*”

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)“*e.*”

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)“*f.*”

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

*h.* An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

*i.* Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider’s corrective actions. Providers may be given technical assistance as needed.

*j.* Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.39(11) Departmental reviews.** Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

*a.* Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

*b.* Following a departmental review, the department shall submit a copy of the department’s determined survey report to the service provider, noting service deficiencies and strengths.

*c.* The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

*d.* The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

*e.* The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11) “*c*” and “*d*.”

*f.* The department may conduct a site visit to verify all or part of the information submitted.

**77.39(12) *Case management service providers.*** Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

**77.39(13) *Supported community living providers.***

*a.* The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

*b.* Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

*c.* Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

*d.* The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

*e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

*f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**77.39(14) *Respite service providers.*** Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

*a.* The following agencies may provide respite services:

- (1) Respite providers certified under the HCBS intellectual disability waiver.
- (2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
- (3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (4) Camps certified by the American Camping Association.
- (5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- (8) Home health agencies that are certified to participate in the Medicare program.
- (9) Agencies certified by the department to provide respite services in the consumer’s home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.39(15) Supported employment providers.**

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

**77.39(16) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.39(17) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

**77.39(18) Transportation service providers.** This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.39(19) Specialized medical equipment providers.** The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

**77.39(20) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.39(21) Family counseling and training providers.** Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*d.* Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*e.* Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

**77.39(22) *Prevocational services providers.*** Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

**77.39(23) *Behavioral programming providers.*** Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

*a.* Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

*b.* Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

**77.39(24) *Consumer-directed attendant care providers.*** The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.39(25) Interim medical monitoring and treatment providers.**

a. The following providers may provide interim medical monitoring and treatment services:

- (1) Home health agencies certified to participate in the Medicare program.
- (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- (1) Be at least 18 years of age.
- (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
- (3) Not be a usual caregiver of the member.
- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.39(26) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.39(27) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.39(28) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.39(29) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.39(30) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 1638C**, IAB 10/1/14, effective 11/5/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

**441—77.40(249A) Lead inspection agencies.** The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

**441—77.41(249A) HCBS physical disability waiver service providers.** Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed

community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

**77.41(1) Enrollment process.** Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

*a.* Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

*b.* Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.41(2) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide consumer-directed attendant care and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies that are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.103.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.41(3) Home and vehicle modification providers.** The following providers may provide home and vehicle modifications:

*a.* Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

*b.* Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.41(4) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

**77.41(5) Specialized medical equipment providers.** The following providers may provide specialized medical equipment:

*a.* Medical equipment and supply dealers participating as providers in the Medicaid program.

*b.* Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

**77.41(6) Transportation service providers.** The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.41(7) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.41(8) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.41(9) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.41(10) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.41(11) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

**77.41(12) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. *Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer 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 consumer;

4. Requires the intervention of law enforcement;

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

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and 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.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the 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 consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar 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 about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time 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 waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.42(249A) Public health agencies.** Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

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

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

**441—77.43(249A) Infant and toddler program providers.** An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and

the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

**77.43(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.43(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

**441—77.44(249A) Local education agency services providers.** School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

**77.44(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

- (2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- (3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
  - g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).
  - h. Medical transportation shall be provided by licensed drivers.
  - i. Other services shall be provided by staff who are:
    - (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
    - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
    - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
    - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
    - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
    - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
    - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
    - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
    - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
    - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.44(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

- a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b. An assessment and response to interventions and services.
- c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

**441—77.45(249A) Indian health service 638 facilities.** A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

**77.45(1) Licensure.** Services must be rendered by practitioners who meet applicable professional licensure requirements.

**77.45(2) Documentation.** Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

**441—77.46(249A) HCBS children's mental health waiver service providers.** HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another

HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

**77.46(1) General provider standards.** All providers of HCBS children's mental health waiver services shall meet the following standards:

*a. Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

*b. Direct care staff.*

(1) Direct care staff must be at least 18 years of age.  
(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

*c. Outcome-based standards and quality assurance.*

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

*d. Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. **EXCEPTION:** The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer 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 consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and 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.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the 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 consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time 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 waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.46(2)** *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

- a. A community business that:
  - (1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and
  - (2) Submits verification of current liability and workers' compensation insurance.
- b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.
- c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.
- d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.
- e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

**77.46(3)** *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

- (1) Behavioral health intervention providers qualified under 441—77.12(249A).
- (2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1) "c" for the children's mental health waiver.
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. *Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

- (1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.
- (2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(4)** *In-home family therapy providers.*

*a. Qualified providers.* The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1) "c" for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(5) Respite care providers.**

*a. Qualified providers.* The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.  
(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1) "c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Consumer-specific information.* The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

*d. Written notification of injury.* The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

*e. Medication dispensing.* Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

*f. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*g. Service documentation.* Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

*h. Capacity.* A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

*i. Service provided outside home or facility.* For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.47(249A) Health home services providers.** Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

**77.47(1) Qualifications.** A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

*a. Staffing.* At a minimum, a qualifying provider must fill the following roles:

(1) Designated practitioner.

(2) Dedicated care coordinator.

(3) Health coach.

(4) Clinic support staff.

*b. Data management.* A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

*c. Collaboration with case managers.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

*d. Provision of integrated health home services.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(3) or (4) must be integrated health homes that:

(1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);

(2) Have a direct agreement with an Iowa Medicaid managed care organization to provide health home services for members with SMI or SED;

(3) Coordinate all community and social support services needs for members enrolled in the health home; and

(4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

**77.47(2) Report on quality measures.** As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

**77.47(3) Selection.** As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.48(249A) Speech-language pathologists.** Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

**77.48(1)** Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.48(2)** Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.

[ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—77.49(249A) Physician assistants.** All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with facilities or supervising providers.

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

[ARC 0580C, IAB 2/6/13, effective 4/1/13]

**441—77.50(249A) Ordering and referring providers.** A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0580C, IAB 2/6/13, effective 4/1/13]

**441—77.51(249A) Child care medical services.** Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

[ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.52(249A) Community-based neurobehavioral rehabilitation services.**

**77.52(1) Definitions.**

*“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.

*“Brain injury”* means a diagnosis in accordance with rule 441—83.81(249A).

*“Health care”* means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

*“Intermittent community-based neurobehavioral rehabilitation services”* means services provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

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

*“Neurobehavioral rehabilitation”* refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

*“Standardized assessment”* means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

**77.52(2) Eligible providers.** The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

*a.* An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

*b.* Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

**77.52(3) Provider standards.** All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

*a.* The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

- (1) The organization shall provide high-quality supports and services to members.
- (2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.
- (3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.
- (4) The program administrator shall be a certified brain injury specialist trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor's degree in a human services-related field;
2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;
3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or
4. Be a certified brain injury specialist or have other brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members, including but not limited to:

1. Promotion of a program structure and support for persons served so they can re-learn or regain skills for community inclusion and access.
2. Compensatory strategies to assist in managing ADLS (activities of daily living).
3. Quality of life issues.
4. Behavioral supports and identification of antecedent triggers.
5. Health and medication management.
6. Dietary and nutritional programming.
7. Assistance with identifying and utilizing assistive technology.
8. Substance abuse and addiction issues.
9. Self-management and self-interaction skills.
10. Flexibility in programming to meet members' individual needs.
11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial and medical needs.
12. Community accessibility and safety.
13. Household maintenance.
14. Service support to the member's family or support system related to the member's neurobehavioral care.

*b.* The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum the training includes the following:

- (1) Completion of the department-approved brain injury training modules.
- (2) Member rights.
- (3) Confidentiality and privacy.
- (4) Dependent adult and child abuse prevention and mandatory reporter training.
- (5) Individualized rehabilitation treatment plans.
- (6) Major mental health disorder basics.

*c.* Within 30 days of commencement of direct service provision, employees shall complete cardiopulmonary resuscitation (CPR) training, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually.

*d.* Within the first six months of commencement of direct service provision, employees shall complete training required by 441—subparagraph 78.54(3)“a”(6).

*e.* Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training.

*f.* The organization shall have in place an outcome management system which measures the efficiency and effectiveness of service provision, including members’ preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

*g.* The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

(1) Measure and analyze organizational activities and services quarterly.

(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.

(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

*h.* The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

*i.* The organization’s governing body shall have an active role in the administration of the organization.

*j.* The organization’s governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

*k.* The organization shall implement the following outcome-based standards for rights and dignity:

(1) Members are valued.

(2) The member and the member’s treatment team mutually develop an individualized service plan (ISP) that takes into account the member’s individual strengths, barriers and interests. The service plan shall include goals which are based on the member’s need for services and shall address the neurobehavioral challenges and environmental needs as identified in the member’s individual standardized comprehensive functional neurobehavioral assessment.

(3) The member and the member’s treatment team evaluate the member’s progress towards treatment goals regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member’s status or needs change to reflect the member’s progress and response to treatment.

(4) The member and the member’s legal representative have the right to file grievances regarding the provider’s implementation of the organizational standards, or its employee’s or contractual person’s action which affects the member. The provider shall provide to members the policies and procedures for member grievances and appeals at the commencement of services and annually thereafter.

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with 481—subrule 63.23(4), rule 481—63.33(135C), and rule 481—63.37(135C). When a member has a guardian or legal representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

1. Restraint, including chemical restraint, manual restraint or mechanical restraint;
  2. Alarms added to a member's natural environment including doors, windows, refrigerators, cabinets, and other home appliances and fixtures;
  3. Exclusionary time out;
  4. Intensive staffing for control of behavior;
  5. Limited access or contingency access to preferred items or activities naturally available in the member's environment;
  6. Reprimand;
  7. Response cost; and
  8. Use of psychotropic medications to control the occurrence of an unwanted behavior.
- (6) Members receive individualized services.
- (7) Members or their legal representatives provide written consent regarding which personal information is shared and with whom.
- (8) Members receive assistance with accessing financial management services as needed.
- (9) Members receive assistance with obtaining preventive, appropriate and timely medical and dental care.
- (10) The member's living environment is reasonably safe and located in the community.
- (11) The member's desire for intimacy is respected and supported.

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

*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 IME medical services unit 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 IME medical services unit 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 IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

*h.* Elective, non-medically necessary cesarean section (C-section) deliveries.

**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.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

*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 for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

*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 441—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 441—paragraph 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 IME medical services unit 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 IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the IME medical services unit and the department. If not so approved by the IME medical services unit, 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 the IME medical services unit.

**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 stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia 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 IME medical services unit. (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 for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart 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, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (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 IME medical services unit. (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 IME medical services unit. (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 version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are 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; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

**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, optometrist, physician assistant, or advanced registered nurse

practitioner). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

**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 for anorexia, weight gain, or weight loss.

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

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(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)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

**78.2(5) Nonprescription drugs.**

a. 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 500 mg, 750 mg, 1000 mg, 1250 mg  
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 lozenge 2 mg, 4 mg  
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day  
 Pediatric oral electrolyte solutions  
 Permethrin lotion 1%  
 Polyethylene glycol 3350 powder  
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg  
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml  
 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.

*b.* Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

**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; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**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 Medicaid enterprise. 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. 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 the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, 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.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**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 the IME medical services unit 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 the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit 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 the IME medical services unit 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 the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit 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 normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

**78.3(16)** Skilled nursing care in “swing beds.”

*a.* 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. Swing-bed placement is only intended to be short-term in nature.

*b.* Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

- (1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
- (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member's LOC needs, using Form 470-5156, Swing Bed Certification.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member's LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member's needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

**78.3(17)** Rescinded IAB 8/9/89, effective 10/1/89.

**78.3(18)** Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (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.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0844C**, IAB 7/24/13, effective 7/1/13; **ARC 1054C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

**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. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

**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 a physical or mental condition, 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 every 90 days. (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 condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge

to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

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

- a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.
- b. A periodic oral examination is payable once in a six-month period.
- c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full 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 dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.
- l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

**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. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.
  - (1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.
  - (2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.
  - (3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.
  - (4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.
- e. Cast post and core, post and composite or post and amalgam in addition to a crown are 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 restoration procedures:
  - (1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(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) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

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

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (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. 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 member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross-reference 78.28(2)“a”(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2)“a”(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

**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 there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

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, including 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 is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year 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) "c")

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 since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

**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. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.
- j. 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 or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.
- b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.
- c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, 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. Six months' postdelivery care is included in the reimbursement for the denture. (Cross-reference 78.28(2) "b"(1))
- d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross-reference 78.28(2) "b"(2))

*e.* A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

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

*g.* Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

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

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

*j.* 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.

*k.* 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.

*l.* Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

*m.* A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

*n.* An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

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

*a.* Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross-reference 78.28(2) "c")

*b.* Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

*c.* Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

**78.4(9) *Adjunctive general services.*** Payment may be made for the following:

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

*b.* 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.

*c.* 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 examinations are not billed for that visit.

*d.* 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.

*e.* 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 the writing of prescriptions.

*f.* Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

*g.* Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

**78.4(10)** *Orthodontic 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.

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13]

**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 paragraph 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.** 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 with a three-mirror lens.

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

(1) When spectacle 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 spectacle 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) Spectacle lenses made from polycarbonate or equivalent material 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 seven years of age.
      3. When there is a covered 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 or result in frequent breakage.
  - 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 one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.
  - i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:
    - (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
    - (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
    - (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
    - (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
    - (5) Soft contact lenses and replacements are allowed when medically necessary.
- 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.
  - b. Standard plastic, plastic and metal combination, or metal frames.

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. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle 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) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

**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 at or 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.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(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 occupational eye safety.
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Sunglasses.
- f. Progressive bifocal or trifocal lenses.

**78.6(6) Therapeutically certified optometrists.** Rescinded IAB 9/5/12, effective 11/1/12.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12]

**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	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

\* NEC means not elsewhere classified.

*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.  
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

**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 plan of care must be signed and dated by the physician

before the claim for service is submitted for reimbursement.

**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.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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 member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

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

*e.* The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5)"k" for prior authorization requirements.

*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 and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

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.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)"n" for prior authorization requirements.

**78.10(2) Durable medical equipment.** DME is equipment that 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 provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
  - The dates of each initial, periodic and ending reading, and
  - Evidence of ongoing need for oxygen services.
4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.
5. Oxygen prescribed "PRN" or "as necessary" is not payable.
6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)"f" for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

(4) Medicaid will provide separate payment for customized wheelchairs for members who are residents of nursing facilities, subject to the following:

1. The member's condition must necessitate regular use of a wheelchair on a long-term basis to enable independent mobility within the facility.

2. The member must require a wheelchair that is designed, assembled, modified, or constructed for the specific individual, in whole or in part, based on the individual's condition, measurements, and needs.

3. Prior authorization pursuant to rule 441—79.8(249A) is required.

*b.* The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5) "d" for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5) "g" and "j" for prior authorization requirements.

Commode, shower commode chair. See 78.10(5) "j" for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5) "a" for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5) "c" for prior authorization requirements.

Insulin infusion pump. See 78.10(5) "b" and 78.10(5) "e" for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5) "i" for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2) "a" and 78.10(2) "c."

Patient lift. See 78.10(5) "h" for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5) "f" for prior authorization requirements.

Traction equipment.

Ventilator.

*c.* Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner 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 yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member'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, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

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

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

**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 member’s condition may improve sometime in the future.

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

*b.* The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See 78.10(5) “l” for prior authorization requirements.

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

(5) Orthotic devices. See 78.10(3) “c” for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) 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.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) 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.* 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 documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks 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.* The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

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 supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) “e” for prior authorization requirements.  
 Dialysis supplies.  
 Disposable catheterization trays or sets (sterile).  
 Disposable irrigation trays or sets (sterile).  
 Disposable saline enemas (e.g., sodium phosphate type).  
 Dressings.  
 Elastic antiembolism support stocking.  
 Enema.  
 Hearing aid batteries.  
 Incontinence products (for members three years of age and older).  
 Oral nutritional products. See 78.10(5) “m” for prior authorization requirements.  
 Ostomy appliances and supplies.  
 Respirator supplies.  
 Shoes, diabetic.  
 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 persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).  
 Diabetic supplies (including but not limited to lancing devices, lancets, 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).  
 Ostomy appliances and supplies.  
 Shoes, diabetic.

**78.10(5) Prior authorization requirements.** Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

*a.* Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member’s mobility puts the member at risk for injury.

*b.* External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

*c.* Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member 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 in lung function.

(2) The member 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.

*d.* 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 per 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.

*e.* Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

*f.* Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

*g.* Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

*h.* Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

*i.* Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

(1) Has a sip 'n puff attachment, or

(2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or

(3) The medical documentation demonstrates the member becomes fatigued.

*j.* Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

(1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and

(2) Needs upper body support while sitting, and

(3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

*k.* Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

*l.* Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

*m.* Oral nutritional products. Payment shall be approved 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 persons with an intellectual disability.

*n.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

(1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and

(2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

*o.* Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2) "a"(4).

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; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14]

**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 441—paragraph 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) Behavioral health intervention.** Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

**78.12(1) Definitions.**

“Behavioral health intervention” means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member’s integration and stability in the community and quality of life;
2. Improving a member’s health and well-being related to the member’s mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member’s best possible functional level; and
3. Promoting a member’s mental health recovery and resilience through increasing the member’s ability to manage symptoms.

“Licensed practitioner of the healing arts” or “LPHA,” as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Mental disorder” means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

**78.12(2) Covered services.**

*a. Service setting.*

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member’s family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member’s age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

*b. Crisis intervention.* Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed 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.

(3) Crisis intervention services do not include control room or other restraint activities.

*c. Behavior intervention.* Behavior intervention includes services designed 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 in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

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

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

*d. Family training.* Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

*e. Skill training and development.* Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

**78.12(3) Excluded services.**

*a.* Services that are habilitative in nature are not covered under behavioral health intervention. 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.

*b.* Respite, day care, education, and recreation services are not covered under behavioral health intervention.

**78.12(4) Coverage requirements.** Medicaid covers behavioral health intervention 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.

*b.* The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

*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 every six months thereafter if continued services are ordered.

*d.* The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

**78.12(5) Approval of plan.** The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

*a. Initial plan.* The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(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 meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

*b. Subsequent plans.* The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“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; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

**78.12(6) Medical necessity.** Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

*a.* Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

*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 evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

**441—78.13(249A) Nonemergency medical transportation.** The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

**78.13(1) Covered services.** Nonemergency medical transportation services available are limited to:

*a.* The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
  - (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
  - (3) Taxi service.
  - (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
  - (5) Wheelchair and stretcher vans.
  - (6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.
- b.* Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.
- c.* Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.
- d.* Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.
- e.* Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

**78.13(2) Exclusions.** Nonemergency medical transportation is not available through the Iowa Medicaid program for:

- a.* Transportation to obtain services not covered by Iowa Medicaid;
- b.* Transportation to providers that are not enrolled in Iowa Medicaid;
- c.* Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
- d.* Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
- e.* Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
- f.* Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;
- g.* Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and
- h.* Emergency transportation.

**78.13(3) Conditions and limitations on covered services.** Nonemergency medical transportation services are subject to the following limitations and conditions:

*a. Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

*b. No free transportation alternatives available.* Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

*c. No member transportation alternatives available.* Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

*d. Limitations on reimbursement for meals.* Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

*e. Limitations on reimbursement for lodging expenses.* Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

*f. Closest medical provider.* Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

*g. Member scheduling obligations.* Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

*h. Abusive behavior.* Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

*i. Member claim submission.* Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

**78.13(4) Grievance procedure.** The broker shall establish an internal grievance procedure for members and transportation providers.

*a.* Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”

*b.* Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[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; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

**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)** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**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.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

#### **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 member'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 to a member residing in a residential care facility are payable when the facility submits a signed statement 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 member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(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.  
[ARC 0994C, IAB 9/4/13, effective 11/1/13]

**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.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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)** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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).)

**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.

**78.25(4) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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 IME medical services unit 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 the IME medical services unit. (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; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.27(249A) Home- and community-based habilitation services.** Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise.

**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.

*"Care coordinator"* means the professional who assists members in care coordination as described in paragraph 78.53(1) "b."

*"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.

“*Integrated health home*” means the provision of services to enrolled members as described in subrule 78.53(1).

“*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.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*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 or integrated health home care coordinator has completed an assessment of the member’s need for service, and based on that assessment, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The designated case manager or integrated health home care coordinator 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 comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before 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 member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

**78.27(4) *Comprehensive service plan.*** Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment 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 or treatment 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 or the integrated health home care coordinator shall establish an interdisciplinary team for the member. The team shall include the case manager or integrated health home care coordinator 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 or integrated health home care coordinator 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.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

*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 or treatment 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 or treatment 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 or treatment 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 comprehensive service plan or treatment 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. Exclusions.*

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) 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 15 minutes. A maximum of 104 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) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) 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.** Rescinded IAB 7/11/12, effective 7/1/12.

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); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.**

**78.28(1)** Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code 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. Payment shall be approved pursuant to the criteria at 78.10(5)“*d.*”

*c.* Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“*l.*”

*d.* Rescinded IAB 5/11/05, effective 5/1/05.

*e.* Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“*f.*”

*f.* Preprocedure review by the IME medical services unit 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 IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, 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 the IME medical services unit.

*g.* Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“*a.*”

*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.* Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“*m.*”

*j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“*c.*”

*k.* Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5)“*e.*”

*l.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“*n.*”

- m.* Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) “g.”
- n.* Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) “h.”
- o.* Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) “i.”
- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) “j.”
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2) “a”(4).

**78.28(2)** Dental services. Dental services which require prior approval are as follows:

- a.* The following periodontal services:
  - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) “b.”
  - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) “d.”
  - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) “e.”
  - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) “f.”
  - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) “g.”
- b.* The following prosthetic services:
  - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “b.”
  - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “d.”
  - (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “c.”
  - (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “e.”
  - (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7) “k.”
  - (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7) “l.”
  - (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7) “m.”
  - (8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7) “n.”
- c.* The following orthodontic services:
  - (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) “a.”
  - (2) Interceptiv orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “b.”
  - (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “c.”
- d.* The following restorative services:
  - (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) “d”(3).
  - (2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) “d”(4).
- e.* Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) “d.”
- f.* Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) “g.”

**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.

*d.* Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

*e.* Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

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 retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross-reference 441—78.3(249A))

*c.* Preprocedure review by the IME medical services unit 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 IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

**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)** All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

*a.* Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

*b.* A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

**78.28(8)** Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

**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")

**78.28(11)** High-technology radiology procedures.

*a.* Except as provided in paragraph 78.28(11) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

*b.* Notwithstanding paragraph 78.28(11) "a," prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member's receipt of such notice (see paragraph 78.28(11) "e"); or

(4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

*c.* Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

*d.* Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department's contractor for prior approval of high-technology radiology procedures.

*e.* Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member's retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

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; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**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, master social worker, mental health counselor, or certified alcohol and drug counselor 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.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

**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.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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 IME medical services unit. 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. Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**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 or bulimia nervosa. Compulsive overeaters are not approved 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 nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

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 dysrhythmia 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.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**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 will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.34(249A) HCBS ill and handicapped waiver services.** Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

**78.34(1) Homemaker services.** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- 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 member, and washing dishes.
- c. 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 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**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 member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Services provided outside the member'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.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

*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 services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.34(6) Counseling services.** Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member 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 member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. 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 member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member'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.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members 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, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as 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.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.34(8)** *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a.* Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

*b.* Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

*c.* Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

*d.* Limitations.

- (1) A maximum of 12 hours 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. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

*e.* A unit of service is 15 minutes.

**78.34(9)** *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member'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, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle 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 member'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 prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

(1) Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.34(10) Personal emergency response or portable locator system.**

a. 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.

- (1) The required components of the system are:
  1. An in-home medical communications transceiver.
  2. A remote, portable activator.



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). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(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.

**78.34(14) General service standards.** All ill and handicapped waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) 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.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) 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.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

**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 members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

**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 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.37(2) Personal emergency response or portable locator system.**

*a.* 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.

- (1) The necessary components of a 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 at all times.
  4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

*b.* A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
  1. A portable communications transceiver or transmitter to be worn or carried by the member.
  2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**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 member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- 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 member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

**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 member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member'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. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- 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 services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.37(7) *Chore services.*** Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7)“a,” as necessary to allow a member to remain in the member’s own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

- (1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
- (2) Minor repairs to walls, floors, stairs, railings and handles;
- (3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;
- (4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

**78.37(8) *Home-delivered meals.*** Home-delivered meals are meals prepared elsewhere and delivered to a member at the member’s residence.

a. Each meal shall ensure the member 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.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

**78.37(9) *Home and vehicle modification.*** Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member’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, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle 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 member’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 prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

*f.* All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

*g.* Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

*h.* Services shall be included in the member'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 members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**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.

*a.* The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

*b.* The service shall be provided following prior approval by the Iowa Medicaid enterprise.

*c.* Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**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 15 minutes.

**78.37(15) *Consumer-directed attendant care service.*** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15) "*f*" and the skilled activities listed in paragraph 78.37(15) "*g*." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member'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.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members 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, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as 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.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.

- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

**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). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(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.

**78.37(18) *Assisted living service.*** The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

*a.* A unit of service is one day.

*b.* A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

**78.37(19) *General service standards.*** All elderly waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

*c.* Services must be billed in whole units.

*d.* For all services with a 15-minute unit of service, the following rounding process will apply:

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

(2) 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.

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

(4) 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.

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; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16]

**441—78.38(249A) HCBS AIDS/HIV waiver services.** Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

**78.38(1) *Counseling services.*** Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member 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 member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the

member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. 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 member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- 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 member, and washing dishes.
- c. 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 member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member'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. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- 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 services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.38(6) Home-delivered meals.** Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

*a.* Each meal shall ensure the member 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.

*b.* When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

*c.* A maximum of two meals is allowed per day. 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 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.38(8) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member'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.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members 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, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as 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., antihypertensive, 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.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**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). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

- (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.
  1. *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.

**78.38(10) General service standards.** All AIDS/HIV waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

*c.* Services must be billed in whole units.

*d.* For all services with a 15-minute unit of service, the following rounding process will apply:

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

(2) 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.

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

(4) 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.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

**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.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**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.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.41(249A) HCBS intellectual disability waiver services.** Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

**78.41(1) Supported community living services.** Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

*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 activities which assist a member 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 member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member'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 activities which assist a member 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 member 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 activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member'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 member 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 members 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 periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

*c.* Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

*d.* A member aged 17 or under living in the home of the member's family, legal representative, or foster family 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.

*e.* Maintenance and room and board costs are not reimbursable.

*f.* Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

*g.* The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

*h.* The service shall be identified in the member's service plan.

*i.* Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

**78.41(2) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Services provided outside the member'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.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

*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 services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

*i.* Payment for respite services shall not exceed \$7,262 per the member's waiver year.

**78.41(3) Personal emergency response or portable locator system.**

*a.* The 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.

(1) 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 at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

*b.* A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.41(4) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member'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, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle 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 member'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 prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

*f.* All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member'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 member 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 intellectual disability waiver 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 member's service 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 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 rehabilitative goals. Three conditions must be met before services are provided. First, the member 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 member's interdisciplinary team must determine that the identified services are necessary. Third, the member'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 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:

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 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 441—subrule 83.67(1). 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:

1. Developing relationships with employers and providing leads for individual members 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 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 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 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.

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 member 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 member 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 members in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is 15 minutes.

(4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member'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 members seek, obtain, or maintain employment must be persons without disabilities. 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.

(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 member.

(6) All services shall be identified in the member'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 members 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 member 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 member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) "f" and the skilled activities listed in paragraph 78.41(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member'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.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members 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, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as 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.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

**78.41(9) *Interim medical monitoring and treatment services.*** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a. Need for service.* The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

*b. Service requirements.* Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

*c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.*

*d. Limitations.*

- (1) A maximum of 12 hours 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. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
  - (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
  - (5) The member-to-staff ratio shall not be more than six members to one staff person.
  - (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.
- e.* A unit of service is 15 minutes.

**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 members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

**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 in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.41(13) *Prevocational services.*** Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, 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 member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

*c.* A unit of service is a full day (4.25 to 8 hours) or an hour (for up to 4 hours per day).

**78.41(14) *Day habilitation services.***

*a. Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member'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 member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

*c. Unit of service.* Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

*d. Exclusions.*

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member'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). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)“b” must be based on the skill level of the

legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(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.

*1. 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.

**78.41(16) General service standards.** All intellectual disability waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

*c.* Services must be billed in whole units.

- d.* For all services with a 15-minute unit of service, the following rounding process will apply:
- (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) 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.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) 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.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

**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 (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.43(249A) HCBS brain injury waiver services.** Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

**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 eligible for targeted case management 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 member's home and community, according to the individualized member need as identified in the service plan.

*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 activities which assist a member 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 member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member'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 activities which assist a member 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 member 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 member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member'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 member 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 members 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 periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

*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 four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

*d.* A member aged 17 or under living in the home of the member's family, legal representative, or foster family 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.

*e.* Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"*e*"(1) does not apply.

*f.* The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

*g.* The service shall be identified in the member's service plan.

*h.* Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

**78.43(3) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Services provided outside the member'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.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

*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 services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

**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 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 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 member's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member'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 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:

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 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 rule 441—83.87(249A). 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:

1. Developing relationships with employers and providing leads for individual members 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 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 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.

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 member 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 member 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 members in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.
      - (3) A unit of service is 15 minutes.
      - (4) A maximum of 160 units may be received per week.
  - c. The following requirements apply to all supported employment services:
    - (1) Employment-related adaptations required to assist the member within the performance of the member’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 members seek, obtain, or maintain employment must be persons without disabilities. 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.
    - (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 member.
    - (6) All services shall be identified in the member’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 members 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 member 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 modification.** Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.
- a. Modifications that are necessary or desirable without regard to the member’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, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle 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 member'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 prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.43(6) Personal emergency response or portable locator system.**

a. 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.

(1) The necessary components of a 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 at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

*b.* A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.43(7) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

**78.43(8) *Specialized medical equipment.***

*a.* Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

*b.* Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

*c.* Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

*d.* The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

*e.* Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**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 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25

to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**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 which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, 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 which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which 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)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

*c.* A unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 hours per day).

**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 member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) "f" and the skilled activities listed in paragraph 78.43(13) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member'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.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members 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, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as 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.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.43(14) Interim medical monitoring and treatment services.** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a.* Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical

intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours 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. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

**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). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(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.

**78.43(16) General service standards.** All brain injury waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) 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.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) 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.

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; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

**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) Assertive community treatment.** Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

**78.45(1) Applicability.** ACT services may be provided only to a member who meets all of the following criteria:

*a.* The member is at least 17 years old.  
*b.* The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

*c.* The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

*d.* The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

*e.* The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

*f.* At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

*g.* The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

**78.45(2) Services.** The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

*a. Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

*b. Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

*c. Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

*d. Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

*e. Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

*f. Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

*g. Crisis response.* Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

*h. Work-related services.* Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—78.46(249A) Physical disability waiver service.** Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

**78.46(1) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member'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.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members 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, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as 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.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.46(2) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member'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, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle 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 member'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 prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.46(3)** *Personal emergency response or portable locator system.*

a. 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.

(1) The necessary components of a 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 at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law

enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
  1. A portable communications transceiver or transmitter to be worn or carried by the member.
  2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.46(4) *Specialized medical equipment.***

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.46(5) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**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). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(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.

**78.46(7) General service standards.** All physical disability waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) 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.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) 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.

This rule is intended to implement Iowa Code section 249A.4.  
 [ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

**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) Public health agencies.** Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

**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.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

*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.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**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 members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan.

**78.52(1) General service standards.** All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

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

(2) 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.

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

(4) 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.

**78.52(2) Environmental modifications and adaptive devices.**

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.52(3) Family and community support services.** Family and community support services shall support the member and the member'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 member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member 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 member's interdisciplinary team pursuant to 441—Chapter 83.

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 member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member 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 member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member'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 member 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 have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid 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.

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 care.

f. A unit of family and community support services is 15 minutes.

**78.52(4) *In-home family therapy.*** In-home family therapy provides skilled therapeutic services to the member 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 member 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 15 minutes.

**78.52(5) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Respite services provided outside the member'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.

*b.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

*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 members 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.

*h.* Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13]

**441—78.53(249A) Health home services.** Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

**78.53(1) Covered services.** Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

*a.* Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

*b.* Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

*c.* Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

(2) Improving disease control; and

- (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
  - d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
    - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
    - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
  - e. Member and family support (including authorized representatives). This support may include:
    - (1) Communicating with and advocating for the member or family for the assessment of care decisions;
    - (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
    - (3) Increasing health literacy and self-management skills; and
    - (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.
  - f. Referral to community and social support services available in the community.
- 78.53(2) Members eligible for health home services.**
- a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:
    - (1) Has at least two chronic conditions;
    - (2) Has one chronic condition and is at risk of having a second chronic condition;
    - (3) Has a serious mental illness; or
    - (4) Has a serious emotional disturbance.
  - b. For purposes of this rule, the term "chronic condition" means:
    - (1) A mental health disorder.
    - (2) A substance use disorder.
    - (3) Asthma.
    - (4) Diabetes.
    - (5) Heart disease.
    - (6) Being overweight, as evidenced by:
      1. Having a body mass index (BMI) over 25 for an adult, or
      2. Weighing over the 85th percentile for the pediatric population.
    - (7) Hypertension.
  - c. For purposes of this rule, the term "serious mental illness" means:
    - (1) A psychotic disorder;
    - (2) Schizophrenia;
    - (3) Schizoaffective disorder;
    - (4) Major depression;
    - (5) Bipolar disorder;
    - (6) Delusional disorder; or
    - (7) Obsessive-compulsive disorder.
  - d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

**78.53(3) Selection of health home services provider.** As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

**441—78.54(249A) Speech-language pathology services.** Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—78.55(249A) Services rendered via telehealth.** An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

**441—78.56(249A) Community-based neurobehavioral rehabilitation services.** Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

**78.56(1) Definitions.**

*“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.

*“Brain injury”* means a diagnosis in accordance with rule 441—83.81(249A).

*“Health care”* means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

*“Intermittent community-based neurobehavioral rehabilitation services”* are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

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

*“Neurobehavioral rehabilitation”* refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

*“Standardized assessment”* means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

**78.56(2) Member eligibility.** To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

*a. Brain injury diagnosis.* To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

*b. Risk factors.* The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

*c. Need for assistance.* The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

*d. Needs assessment.* The member shall have a standardized comprehensive functional neurobehavioral assessment reviewed or completed by a licensed neuropsychologist, neurologist, M.D., or D.O. The neurobehavioral assessment shall document the member's need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise has determined that the member is in need of specialty neurobehavioral rehabilitation services.

*e. Standards for assessment.* Each member will have had a department-approved, standardized comprehensive functional neurobehavioral assessment completed within the 90 days prior to admission. Each needs assessment will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury, which must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

*f. Emergency admission.* In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

**78.56(3) Covered services.**

*a. Service setting.*

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

- (1) Prescriptive programming to maintain and advance progress made in rehabilitation;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Assistance in obtaining preventative, appropriate and timely medical and dental care;
- (4) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;
- (6) Behavioral and cognitive programming and supports;
- (7) Medication management and consultation with pharmacy;
- (8) Health and wellness management including dietary and nutritional programming;
- (9) Progressive physical strengthening, fitness and retraining;
- (10) Assistance with obtaining and use of assistive technology;
- (11) Sobriety support development;
- (12) Assistance with the self-identification of antecedent triggers;
- (13) Assistance with preparation for transition to less intensive services including accessing the community;
- (14) Flexibility in programming to meet individual needs;
- (15) Assistance with re-learning coping and compensatory strategies;
- (16) Support and assistance in seeking substance abuse and co-occurring disorders services;
- (17) Support and assistance with obtaining legal consultation and services;
- (18) Assistance with community accessibility and safety;
- (19) Assistance with re-learning household maintenance;
- (20) Assistance with recreational and leisure skill development;
- (21) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (22) Opportunities to learn about brain injury and individual needs following brain injury;
- (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (24) Assistance with pursuit of education and employment goals;
- (25) Protective oversight in the residential setting and community;
- (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
- (27) Transitional support and training;
- (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
- (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;
- (8) Assistance with re-learning coping and compensatory strategies;
- (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;

(12) Transitional support and training;

(13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

*d.* Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

*e.* Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

(1) The IME medical services unit will approve the provider's treatment plan if:

1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);

2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;

3. The treatment 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; and

5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

*f.* Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

*g.* Quality review. The IME medical services unit may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.54(249A).

**78.56(4) Medical necessity.** Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation 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.

**78.56(5) Documentation standards.** Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16]

**441—78.57(249A) Child care medical services.** Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

**78.57(1)** Nursing services are 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 a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

**78.57(2)** Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

**78.57(3)** Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

**78.57(4)** Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

**78.57(5)** "Medically necessary" 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, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

**78.57(6)** Requirements.

*a.* Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

*b.* Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

*c.* 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. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

(1) Place of service.

(2) Type of service to be rendered and the treatment modalities being used.

- (3) Frequency of the services.
  - (4) Assistance devices to be used.
  - (5) Date on which services were initiated.
  - (6) Progress of member in response to treatment.
  - (7) Medical supplies to be furnished.
  - (8) 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 primary care provider.
    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 acute recurrence of illness or symptoms.
    9. Medications.
  - (9) Discipline of the person providing the service.
  - (10) Certification period.
  - (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
  - (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.
- 78.57(7)** Nursing, personal care, and psychosocial services do not include:
- a. Services provided to members aged 21 and older.
  - b. Services that require prior authorizations that are provided without regard to the prior authorization process.
  - c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
  - d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
  - e. Transportation services.
  - f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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◇ Two or more ARCs

- <sup>1</sup> Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.  
<sup>2</sup> Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.  
<sup>3</sup> 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.  
<sup>4</sup> 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.  
<sup>5</sup> 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**.  
<sup>6</sup> Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.  
<sup>7</sup> 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.  
<sup>8</sup> May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.



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.

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

**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](http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html).

*d. Fee for service with cost settlement.* 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 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.

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 the maximums listed in subrule 79.1(2) and 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 by more than 4.5 percent.

*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.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$51.08 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
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 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<p>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.</p> <p>2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.</p> <p>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.</p>
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	<p>Effective 7/1/13, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate: Veterans Administration contract rate or \$1.45 per 15-minute unit, \$23.24 per half day, \$46.26 per full day, or \$69.37 per extended day if no Veterans Administration contract.</p> <p>Effective 7/1/13, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider’s rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate, \$1.94 per 15-minute unit, \$30.96 per half day, \$61.80 per full day, or \$78.80 per extended day.</p>
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
Portable locator system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%.  For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.  For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
	For AIDS/HIV and health and disability waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and health and disability waivers effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 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	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Home care agency: Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Nonfacility care: Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Adult day care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum.  For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum.  For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.67 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.
14. Senior companion	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$1.87 per 15-minute unit.
15. Consumer-directed attendant care provided by:  Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/13, \$3.54 per 15-minute unit, not to exceed \$82.53 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.34 per 15-minute unit.
Group	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee for service with cost settlement. See 79.1(1) "d."	For brain injury and elderly waivers: Retrospective cost-settled rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/13: \$9.19 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit. Maximum of 104 units per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit for all activities other than personal care and services in an enclave setting. \$5.20 per 15-minute unit for personal care. \$1.63 per 15-minute unit for services in an enclave setting. \$3,029.62 per month for total service. Maximum of 160 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$11.34 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 7/1/13: Lesser of provider's rate in effect 6/30/13 plus 3%, \$50.66 per day or \$13.87 per hour.
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	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: Not to exceed the maximum ICF/ID rate per day plus 3%.
26. Day habilitation	Fee schedule	Effective 7/1/13: County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute or daily rate. If no 6/30/13 rate: \$3.47 per 15-minute unit or \$67.55 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$24.60 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$15.91 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)"b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	\$25.75 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	See 79.1(24) "d"	Retrospective cost-settled rate.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation	See 79.1(24) "d"	Effective 7/1/13: \$13.47 per hour or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	See 79.1(24) "d"	Effective 7/1/13: Maximum of \$8.75 per 15-minute unit and 104 units per 12 months.
Supports to maintain employment	See 79.1(24) "d"	Effective 7/1/13: \$1.55 per 15-minute unit for services in an enclave setting; \$4.95 per 15-minute unit for personal care; and \$8.75 per 15-minute unit for all other services. Total not to exceed \$2,883.71 per month. Maximum of 160 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11) "r."	Effective 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
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")
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 6/30/13 plus 1%.
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 6/30/13 plus 1%.
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. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	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 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
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 6/30/13 plus 1%.
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 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.	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.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
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 subrules 441—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. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) “a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7) “c”	Rate provided by 79.1(7) “c”

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; 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—Chapter 73	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	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
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. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

**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 for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

*"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.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

*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 79.1(5)“y,” for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)“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 the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

*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 hospitals in Iowa 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. Iowa 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. Out-of-state hospitals do not qualify for direct medical education payments.

(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 \$7,594,294.03. 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. Iowa 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. Out-of-state hospitals do not qualify for indirect medical education payments.

(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 \$13,450,285.14. 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.

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility’s status as a teaching facility or bed size.

8. 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 \$6,959,868.59. 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 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. In addition, the hospital must be a voting member of the National Association of Children’s Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children’s Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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 audit 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."

*ab. Nonpayment for preventable conditions.* Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- |   |  |
|---|--|
| Y | The condition was present or developing at the time of the order for inpatient admission.  |
| N | The condition was not present or developing at the time of the order for inpatient admission.  |
| U | Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.                                     |
| W | Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission. |

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

*ac. Rural 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 qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5) “y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5) “y” and the rural 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.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

**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. Payment reduction for services rendered in facility settings.* Rescinded IAB 10/30/13, effective 1/1/14.

*c. Payment for primary care services.* To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7) “c”). Primary care services furnished on or after January 1, 2015, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7) “c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7) “c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

**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 May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

*a.* Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“g,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“f.”

(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“f.”

(3) 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 average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“g,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“f.”

(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.* An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription pursuant to paragraphs 79.1(8)“a” and “b” for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

*f.* The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.

*g.* For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies’ average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department’s discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.

*h.* Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

**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 inpatient 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.

*n.* The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

**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; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

*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](mailto: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.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

*c. Prospective rates for new providers.*

(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.*

(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.* Rescinded IAB 5/1/13, effective 7/1/13.

*f. Retrospective adjustments.*

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 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.

“*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 OPSS 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 (OPSS) 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.

*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 OPSS 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 OPSS 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 OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular OPSS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPSS APC and services that are not paid under an OPSS APC.

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, such as:</p> <ul style="list-style-type: none"> <li>● Ambulance services.</li> <li>● Clinical diagnostic laboratory services.</li> <li>● Diagnostic mammography.</li> <li>● Screening mammography.</li> <li>● Nonimplantable prosthetic and orthotic devices.</li> <li>● Physical, occupational, and speech therapy.</li> <li>● Erythropoietin for end-stage renal dialysis (ESRD) patients.</li> <li>● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.</li> </ul>	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPSS APC.</p> <ul style="list-style-type: none"> <li>● May be paid when submitted on a different bill type other than outpatient hospital (13x).</li> <li>● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.</li> </ul>
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPSS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> <li>● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or</li> <li>● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or</li> <li>● 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</li> <li>● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.</li> </ul>	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
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: <ul style="list-style-type: none"> <li>● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.</li> <li>● 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.</li> </ul> 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.

Indicator	Item, Code, or Service	OPPS Payment Status
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	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> <li>• Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.”</li> <li>• In all other circumstances, payment is made through a separate APC payment.</li> </ul>
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> <li>• Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.”</li> <li>• In all other circumstances, payment is made through a separate APC payment.</li> </ul>
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>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.”</p> <p>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).</p>

*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 as provided in subparagraphs (1) and (2).

- (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) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

*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—subparagraph 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. Services delivered in the emergency room.* Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

*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 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. Iowa 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. Out-of-state hospitals do not qualify for direct medical education payments.

(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 \$2,766,718.25. 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 and equipment.** Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

**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.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
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 version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

**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.

**79.1(23) Reimbursement for remedial services.** Reimbursement for remedial services provided before July 1, 2011, 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.

*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 services provided prior to July 1, 2013, 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 services provided prior to July 1, 2013, is based on a retrospective cost-related rate calculated using the methodology in paragraphs 79.1(24)“b” and “c.” Reimbursement for all home- and community-based habilitation services provided on or after July 1, 2013, shall be as provided in paragraph 79.1(24)“d.” All rates are subject to the upper limits established in subrule 79.1(2).

*a. Units of service.*

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 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. A 15-minute unit for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

*b. Submission of cost reports.* For services provided prior to July 1, 2013, 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 for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but 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.* For services provided prior to July 1, 2013, 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.

*d. Reimbursement for services provided on or after July 1, 2013.*

(1) For dates of services July 1, 2013, through December 31, 2013, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the fee schedule or interim rate for the service and the provider in effect on June 30, 2013, with no retrospective adjustment or cost settlement. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) "b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the rate in effect on June 30, 2013. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(2) For dates of services from January 1, 2014, through December 31, 2015, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) "b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(3) For dates of services on or after January 1, 2016, providers shall be reimbursed by fee schedule.

**79.1(25)** *Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

*a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).* Effective for services rendered on or after October 1, 2006, 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.

*b. Reimbursement methodology for community mental health centers.* Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

*c. Cost-based reimbursement.* For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the 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.

*d. Reporting requirements.* All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(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.

**79.1(26) Home health services.**

*a.* Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

**79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.**

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) 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 or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(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 interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extensionxls orxlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be e-mailed to [costaudit@dhs.state.ia.us](mailto:costaudit@dhs.state.ia.us) on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) 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 and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates 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 program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program 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 private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

*c. Terminated home health agencies.*

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

**79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.**

*a. New providers.* Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

*b. Established providers.* After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

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; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16]

#### **441—79.2(249A) Sanctions.**

##### **79.2(1) Definitions.**

*“Affiliates”* means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

*“Iowa Medicaid enterprise”* means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

*“Person”* means any individual human being or any company, firm, association, corporation, institution, or other legal entity. *“Person”* includes but is not limited to a provider and any affiliate of a provider.

*“Probation”* means a specified period of conditional participation in the medical assistance program.

*“Provider”* means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member 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 temporary cessation of payments due a person until the resolution of a matter in dispute between a person 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 person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

**79.2(2) *Grounds for sanctions.*** The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

*a.* Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

*b.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

*c.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

*d.* Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

*e.* Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

*f.* Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

*g.* Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

*h.* Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

*i.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

*j.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

*k.* Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

*l.* Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

*m.* Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

*n.* Exclusion from Medicare or any other state or federally funded medical assistance program.

*o.* Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

*p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

*q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

*r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

*s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

*t.* Violation of a condition of probation, suspension of payments, or other sanction.

*u.* Loss, restriction, or lack of hospital privileges for cause.

*v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

*w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

*x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

*y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

**79.2(3) Sanctions.**

*a.* The department may impose any of the following sanctions on any person:

- (1) A term of probation for participation in the medical assistance program.
- (2) Termination from participation in the medical assistance program.
- (3) Suspension from participation in the medical assistance program.
- (4) Suspension of payments in whole or in part.
- (5) Prior authorization of services.
- (6) Review of claims prior to payment.

*b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

*c.* Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

**79.2(4) Imposition and extent of sanction.** The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a.* Seriousness of the offense.
- b.* Extent of violations.
- c.* History of prior violations.
- d.* Prior imposition of sanctions.
- e.* Prior provision of provider education (technical assistance).

- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

**79.2(5) Scope of sanction.**

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

**79.2(6) Notice to third parties.** When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

**79.2(7) Notice of violation.**

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider. The department of inspections and appeals is not required to comply with the additional notification provisions of 441—paragraph 7.10(7) "c" for appeals certified for hearing under this chapter.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, 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. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

**79.2(8) Suspension or withholding of payments.** The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

**79.2(9) Civil monetary penalties and interest.** Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

**79.2(10) Report and return of identified overpayment.**

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.  
 [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15]

**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 shall 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 non-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 program integrity 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) Behavioral health intervention:
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.
- (40) Health home services:
  1. Comprehensive care management plan.
  2. Care coordination and health promotion plan.
  3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
  4. Documentation of member and family support (including authorized representatives).
  5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
  1. Service or office notes or narratives.
  2. Immunization records.
  3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
  1. Department-approved standardized neurobehavioral assessment tool.
  2. Community-based neurobehavioral treatment order.
  3. Treatment plan.
  4. Clinical records documenting diagnosis and treatment history.
  5. Progress or status notes.
  6. Service notes or narratives.
  7. Procedure, laboratory, or test orders and results.
  8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
  9. Medication administration records.
- (43) Child care medical services:
  1. Plan of care.
  2. Certification and recertification.
  3. Service notes or narratives.
  4. Physician orders or medical orders.
  5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
  6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).
    - 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; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16]

#### **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 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 program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at [www.ime.state.ia.us/Providers/Forms.html](http://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.

*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) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(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.

*f.* Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

**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. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible

in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

**441—79.5(249A) Nondiscrimination on the basis of handicap.** All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

**441—79.6(249A) Provider participation agreement.** Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

**79.6(1)** To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

**79.6(2)** That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

**79.6(3)** That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

**441—79.7(249A) Medical assistance advisory council.**

**79.7(1) Officers.** Officers shall be a chairperson and a vice-chairperson.

*a.* The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

*b.* The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

*c.* The vice-chairperson shall serve in the absence of the chairperson.

*d.* The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

*e.* The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

**79.7(2) Membership.** The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

**79.7(3) Expenses, staff support, and technical assistance.** Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

**79.7(4) Meetings.** The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

- a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.
- b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting.

Each notice shall include an agenda for the meeting.

**79.7(5) Procedures.**

- a. A quorum shall consist of 50 percent of the voting members.
- b. Where a quorum is present, a position is carried by two-thirds of the council members present.
- c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.
- d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.
- e. In cases not covered by these rules, Robert's Rules of Order shall govern.

**79.7(6) Duties.**

a. *Executive committee.* Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

- (1) Recommendations on the reimbursement for medical services rendered by providers of services.
- (2) Identification of unmet medical needs and maintenance needs which affect health.
- (3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.
- (4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.
- (5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. *Council.* The medical assistance advisory council shall:

- (1) Advise the professional groups and business entities represented and act as liaison between them and the department.
- (2) Report at least annually to the professional groups and business entities represented.
- (3) Perform other functions as may be provided by state or federal law or regulation.
- (4) Communicate information considered by the council to the professional groups and business entities represented.

**79.7(7) Responsibilities.**

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

- (1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and
- (2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

*f.* The department shall permit staff members to appear before the council to review and discuss specific information and problems.

*g.* The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

**441—79.8(249A) Requests for prior authorization.** This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

**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 must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

*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.

*a.* 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:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

*b.* 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(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.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **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.

**79.9(6)** The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

**79.9(7)** Incorrect payment.

*a.* Except as provided in paragraph 79.9(7)“*b*,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

*b.* Notwithstanding paragraph 79.9(7)“*a*,” medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a

consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

**79.9(8)** The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320. [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

**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 73.

This rule is intended to implement Iowa Code section 249A.4. [ARC 2361C, IAB 1/6/16, effective 1/1/16]

**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 73.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**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. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site. Managed care organizations and fiscal agents are exempt from completing an application.

*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.* Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

*c.* All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

*d.* A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

*e.* An intermediate care facility for persons with an intellectual disability 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, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

*a.* 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.

*b.* With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

*c.* With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

*d.* Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

**79.14(3)** Program integrity information requirements.

*a.* All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

- (2) Has been or is subject to a payment suspension under a federally funded health care program;
- (3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;
- (4) Has had its billing privileges denied or revoked;
- (5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or
- (6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)“a”(1), (2), (3), (4), or (5).

*b.* The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)“c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

*c.* For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

*d.* Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

**79.14(4)** Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

*a.* For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

*b.* Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

*c.* Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state's Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

**79.14(5) Notification.** A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

**79.14(6)** A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

**79.14(7) Effective date of approval.** An application 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 with all required documents by the Iowa Medicaid enterprise provider services unit.

**79.14(8)** A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

**79.14(9)** No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

**79.14(10)** 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, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

**79.14(11)** An amendment to an application 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(12)** A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

**79.14(13) Report of changes.** The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 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, telephone number, or any information required to be disclosed by subrule 79.14(3).

*a.* When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

*b.* When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment 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 or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

**79.14(14)** Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

**79.14(15)** Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

**79.14(16)** Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

**79.14(17)** Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 1153C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**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 Program Integrity 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.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**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 ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. 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 September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine 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 September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

*c.* For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

*d.* For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital 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 applicable criterion in each paragraph of this subrule:

*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, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

*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 enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

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 that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation Web site, 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 Iowa EHR Medicaid incentive payment administration Web site at [www.imeincentives.com](http://www.imeincentives.com). 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, eligible providers 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 CMS Registration and Attestation Web site.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration 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.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

**441—79.17(249A) 2013 reimbursement rate increases.** Rescinded ARC 1056C, IAB 10/2/13, effective 11/6/13.

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     [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]

◊ Two or more ARCs

- <sup>1</sup> 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.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> 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.
- <sup>5</sup> 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**.

- <sup>6</sup> 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.
- <sup>7</sup> 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.
- <sup>8</sup> See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) "b" (ARC 9959B, IAB 1/11/12).



CHAPTER 81  
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]

[Prior to 2/11/87, Human Services[498]]

DIVISION I  
GENERAL POLICIES

**441—81.1(249A) Definitions.**

“*Abuse*” means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“*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 resident is incapacitated.

“*Allowable costs*” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“*Beginning eligibility date*” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“*Case mix*” means a measure of the intensity of care and services used by similar residents in a facility.

“*Case-mix index*” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“*Civil penalty*” shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“*Clinical experience*” means application or learned skills for direct resident care in a nursing facility.

“*Complete replacement*” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“*Cost normalization*” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“*Denial of critical care*” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

“*Department*” means the Iowa department of human services.

“*Direct care component*” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants,

rehabilitation nurses, and contracted nursing services. “Direct care component” also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

“*Discharged resident*” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

“*Facility*” means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“*Facility-based nurse aide training program*” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“*Facility cost report period case-mix index*” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“*Facilitywide average case-mix index*” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“*Informed consent*” means a resident’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., with knowledge of the risks involved or alternatives.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

“*Laboratory experience*” means practicing care-giving skills prior to contact in the clinical setting.

“*Level I review*” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 as amended to July 1, 2014.

“*Level II review*” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“*Major renovations*” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$1.5 million. The \$1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$1.5 million threshold.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medicaid average case-mix index*” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“*Minimum data set*” or “*MDS*” refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16)“b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16)“c” and “e,” the excess payment allowance pursuant to paragraph 81.6(16)“d,” and the limits on reimbursement components pursuant to paragraph 81.6(16)“f.” MDS is described in subrule 81.13(9).

*“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care”* means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

*“Mistreatment”* means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

*“New construction”* means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

*“Non-direct care component”* means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

*“Non-facility-based nurse aide training program”* means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

*“Nurse aide”* means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

*“Nurse aide registry”* means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

*“Nurse aide training and competency evaluation programs (NATCEP)”* are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“PASRR”* means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to July 1, 2014.

*“Patient-day-weighted median cost”* means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

*“Physical abuse”* means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

*“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.

*“Poor performing facility (PPF)”* is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

*“Primary instructor”* means a registered nurse responsible for teaching a state-approved nurse aide training course.

*“Program coordinator”* means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

*“Rate determination letter”* means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

*“Skilled nursing facility level of care”* means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
  - a. A physician order for all skilled services.
  - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
  - c. An individualized care plan that identifies support needs.
  - d. Confirmation that skilled services are provided to the member.
  - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
  - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

*“Skills performance record”* means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

*“Special population nursing facility”* refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 21 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.

*“Surgical or other invasive procedure”* means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. “Surgical or other invasive procedure” does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

*“Terminated from the Medicare or Medicaid program”* means a facility has lost the final appeal to which it is entitled.

“*Testing entity*” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—81.2** Rescinded, effective 11/21/79.

**441—81.3(249A) Initial approval for nursing facility care.**

**81.3(1) *Need for nursing facility care.*** Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

*a.* Decisions on level of care, subject to paragraph 81.3(1) “b,” shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

*b.* For residents subject to a Level II PASRR review pursuant to subrule 81.3(3), the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

*c.* Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

**81.3(2) *Skilled nursing care level of need.*** Rescinded IAB 7/11/01, effective 7/1/01.

**81.3(3) *Preadmission review.*** The department’s contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person’s care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department’s contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

*a.* Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person’s attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person’s physical condition, and the person is not a danger to self or others. If the person’s nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person’s illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson’s disease, Huntington’s chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person’s caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person’s needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and

3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and

4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

*b.* Outcome of Level II review. The Level II review shall determine:

- (1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

- (2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14)“*b*,” using the procedures set forth in 42 CFR 483.134 as amended to July 1, 2014; and

- (3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.13(14)“*c*,” using the procedures set forth in 42 CFR 483.136 as amended to July 1, 2014.

*c.* The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

*d.* Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

- (1) Only if a Level I review was completed prior to admission;

- (2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3)“*a*” has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.

*e.* Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

*f.* A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident's knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility's bringing the state fair hearing on the resident's behalf.

**81.3(4)** *Special care level of need.* Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)“*a*” and 249A.4.  
[ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

**441—81.4(249A) Arrangements with residents.**

**81.4(1)** *Resident care agreement.* Rescinded IAB 12/6/95, effective 2/1/96.

**81.4(2)** *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

**81.4(3)** *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See subrule 81.13(5)“c.”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

*a.* Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

*b.* When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

*c.* Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

*d.* The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

*e.* Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

**81.4(4)** *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

*a.* Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

*b.* Providing adequate storage facilities for the resident's personal effects.

*c.* Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)“a,” and 249A.4.

**441—81.5(249A) Discharge and transfer.** (See paragraph 81.13(6)“c.”)

**81.5(1) Notice.** When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

**81.5(2) Case activity report.** A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

**81.5(3) Plan.** The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

**81.5(4) Transfer records.** When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician's orders for care.
- f. The resident's personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

**81.5(5) Unused client participation.** When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—81.6(249A) Financial and statistical report and determination of payment rate.** With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

**81.6(1) Failure to maintain records.** Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

**81.6(2) Accounting procedures.** Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of "direct patient care costs" and "support care costs." Costs associated with food and dietary wages shall be included in the "support care costs" subcategory.

**81.6(3) Submission of reports.** All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the

facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

*a.* Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

*b.* The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.6(3) "e."

*c.* If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.6(2).

*d.* For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

*e.* A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

*f.* When a nursing facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

*g.* Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

*h.* A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

**81.6(4) Payment at new rate.**

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

(4) Rescinded IAB 9/8/10, effective 8/12/10.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

**81.6(5) Accrual basis.** Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

**81.6(6) Census of public assistance recipients.** Census figures of public assistance recipients shall be obtained on the last day of the month ending the reporting period.

**81.6(7) Patient days.** In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

**81.6(8) Opinion of accountant.** 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 disregard of the certification and reporting instructions.

**81.6(9) Calculating patient days.** When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

**81.6(10) Revenues.** Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding,

pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

*b.* Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

*c.* Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

*d.* Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

*e.* Laundry revenue shall be applied to laundry expense.

*f.* Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

**81.6(11) *Limitation of expenses.*** Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

*a.* Federal and state income taxes are not allowed as reimbursable costs.

*b.* Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

*c.* Bad debts are not an allowable expense.

*d.* Charity allowances and courtesy allowances are not an allowable expense.

*e.* Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

*f.* Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

*g.* Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

*h.* A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11) "h"(4) to 81.6(11) "h"(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

*i.* Management fees paid to a related party shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

*j.* Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 81.6(12).

*k.* Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

*l.* Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

*m.* When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility as identified in subrule 81.6(12), paragraph “a,” plus the landlord’s other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility as identified in subrule 81.6(12), paragraph “a,” plus the landlord’s other expenses.

The landlord must be willing to provide documentation of these costs for rental arrangements.

*n.* Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

*o.* Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

*p.* The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21) “a.”

*q.* Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5) “d.” The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

*r.* Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider's reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

t. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

u. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

v. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

**81.6(12) Termination or change of owner.**

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

**81.6(13) Amended reports.** The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

**81.6(14) Payment to new facility.** The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

**81.6(15) Payment to new owner.** An existing facility with a new owner shall continue to be reimbursed using the previous owner’s per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility’s fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility’s fiscal year will end.

**81.6(16) Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.** This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph “a”) determines the per diem direct care and non-direct care component costs. The second step (paragraph “b”) normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph “c”) calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph “d”) calculates the potential excess payment allowance. The fifth step (paragraph “e”) calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph “h,” that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph “h,” in step six (paragraph “f”). The seventh step (paragraph “g”) calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility’s per diem

allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted

median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16)“a.” In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

*e.* Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph “d,” not to exceed the rate component limits determined by the methodology in paragraph “f.”

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph “d.”

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph “d” and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph “h.”

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

*f.* Notwithstanding paragraphs “d” and “e,” in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph “d” times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility’s achievement of multiple measures suggests that quality is an essential element in the facility’s delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts..	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification

Standard	Measurement Period	Value	Source
Subcategory: Resident Satisfaction			
<p>Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
<p>Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.</p>	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74%  7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

## (6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
<p>Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
<b>Subcategory: Staffing</b>			
<p><b>Nursing Hours Provided:</b> The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation</p> <p>10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
<p><b>Employee Turnover:</b> The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%</p> <p>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
<p><b>Staff Education, Training and Development:</b> The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	Calendar year ending December 31 of the payment period	5 points	Self-certification
<p><b>Staff Satisfaction Survey:</b> The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results

Standard	Measurement Period	Value	Source
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences  5 points if one standard deviation or more below the mean percentage of occurrences	IME medical services unit report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences  5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures  4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

## (7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10%  4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

## (8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation  4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from Form 470-4828, Nursing Facility Medicaid Pay-for-Performance Self-Certification Report, submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16)"g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

*h.* Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “*f.*”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “*f.*” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph “*g.*” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider

Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;

and

- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.
2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement

rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

**81.6(17) Cost report documentation.** All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

- a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.
- b. The starting and average hourly wage for each class of employees for the period of the report.
- c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

**81.6(18) Inflation factor.** The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

**81.6(19) Case-mix index calculation.**

- a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average

case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

*b.* Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

**81.6(20) Medicare crossover claims for nursing facility services.**

*a. Definitions.* For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility 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 reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"Medicaid reimbursement" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

*b. Crossover claims.* Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(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 will 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 is 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.

**81.6(21) Nursing facility quality assurance payments.**

*a. Quality assurance assessment pass-through.* Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

*b. Quality assurance assessment rate add-on.* Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of \$10 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

*c. Use of the pass-through and add-on.* As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment

pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

*d. Effective date.* Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

*e. End date.* If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16, Iowa Code chapter 249K, and 2009 Iowa Code Supplement chapter 249L.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15]

#### **441—81.7(249A) Continued review.**

**81.7(1) Level of care.** The IME medical services unit shall review Medicaid members' need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member's need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

**81.7(2) PASRR.** As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

*a.* Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

*b.* Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and

c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.3(3) "b."

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—81.8(249A) Quality of care review.** Rescinded IAB 8/8/90, effective 10/1/90.

**441—81.9(249A) Records.**

**81.9(1) Content.** The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

**81.9(2) Retention.** Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

**81.9(3) Change of owner.** All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

**441—81.10(249A) Payment procedures.**

**81.10(1) Method of payment.** Except for Medicaid accountability measures payment established in paragraph 81.6(16) "g," facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

**81.10(2) Authorization of payment.** The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

**81.10(3)** Rescinded IAB 8/9/89, effective 10/1/89.

**81.10(4) *Periods authorized for payment.***

*a.* Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

*b.* Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

*c.* Payment will be approved for the day of admission but not the day of discharge or death.

*d.* Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

*e.* Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

*f.* Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility's rate.

*g.* Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

*h.* In-state nursing facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care as determined by the peer review organization shall receive reimbursement for the care of these patients equal to the sum of the Medicare-certified hospital-based nursing facility direct care rate component limit plus the Medicare-certified hospital-based nursing facility non-direct care rate component limit factor pursuant to subparagraph 81.6(16) "f"(3). Facilities may continue to receive reimbursement at this rate for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled care criteria for those 30 days.

*i.* Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

*j.* Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

- (1) The wrong surgical or other invasive procedure is performed on a resident; or
- (2) A surgical or other invasive procedure is performed on the wrong body part; or
- (3) A surgical or other invasive procedure is performed on the wrong resident.

**81.10(5) *Supplementation.*** Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

- a.* Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“a”(4), medical supplies except for those listed in 441—paragraph 78.10(4)“b,” oxygen except under circumstances specified in 441—paragraph 78.10(2)“a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician except for those specified in 441—paragraph 78.1(2)“f.”

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

*b.* The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

*c.* The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“a”(4).

*d.* Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

*e.* The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;
- The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident's family is not willing or able to pay supplementation for the private room;
- The private rooms for which supplementation is available, including a description and identification of such rooms; and
- The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record all of the following:

- A description and identification of the private room for which the nursing facility is receiving supplementation;
- The identity of the individual making the supplemental payments;
- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
- The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

9. The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

10. A private room for which supplementation is required shall be retained for the resident consistent with bed-hold policies.

11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.

- For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

*f.* Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

*g.* The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4) "j" and shall not discharge a resident due to nonpayment for such days.

**81.10(6)** *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

**81.10(7)** *Comparative charges between private pay and Medicaid residents.* Rescinded IAB 2/6/02, effective 4/1/02.

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; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 0714C, IAB 5/1/13, effective 7/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1806C, IAB 1/7/15, effective 3/1/15]

#### **441—81.11(249A) Billing procedures.**

**81.11(1)** *Claims.* Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims must be submitted electronically through Iowa Medicaid's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

**81.11(2)** Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 1806C, IAB 1/7/15, effective 3/1/15]

**441—81.12(249A) Closing of facility.** When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the resident's managed care organization or by the IME medical services unit for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—81.13(249A) Conditions of participation for nursing facilities.** All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

**81.13(1)** *Procedures for establishing health care facilities as Medicaid facilities.* All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

*a.* The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

*b.* The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

*c.* The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

*d.* The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

*e.* The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

*f.* Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

*g.* The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

*h.* The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

*i.* The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

*j.* When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

*k.* Rescinded IAB 12/6/95, effective 2/1/96.

**81.13(2) Medicaid provider agreements.** The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

*a.* Rescinded IAB 2/3/93, effective 4/1/93.

*b.* Rescinded IAB 2/3/93, effective 4/1/93.

*c.* Rescinded IAB 2/3/93, effective 4/1/93.

*d.* Rescinded IAB 2/3/93, effective 4/1/93.

*e.* When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

*f.* Rescinded IAB 2/3/93, effective 4/1/93.

**81.13(3) Distinct part requirement.** All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

*a.* The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

*b.* Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

*c.* Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

**81.13(4) Civil rights.** The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities,

room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

**81.13(5) Resident rights.** The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

*a. Exercise of rights.*

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

*b. Notice of rights and services.*

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

*c. Protection of resident funds.*

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

*d. Free choice.* The resident has the right to:

- (1) Choose a personal attending physician.
- (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.
- (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

*e. Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(2) Except as provided in subparagraph (3) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(3) The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law.

*f. Grievances.* A resident has the right to:

(1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

*g. Examination of survey results.* A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

*h. Work.* The resident has the right to:

- (1) Refuse to perform services for the facility.
- (2) Perform services for the facility if the resident chooses, when:
  1. The facility has documented the need or desire for work in the plan of care.
  2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.
  3. Compensation for paid services is at or above prevailing rates.
  4. The resident agrees to the work arrangement described in the plan of care.
  5. Rescinded IAB 3/4/92, effective 4/8/92.

*i. Mail.* The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage and writing implements at the resident's own expense.

*j. Access and visitation rights.*

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.
2. Any representative of the state.
3. The resident's individual physician.
4. The state long-term care ombudsman.
5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.
6. The agency responsible for the protection and advocacy system for mentally ill individuals.
7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.
8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

*k. Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

*l. Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

*m. Married couples.* The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

*n. Self-administration of drugs.* An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

*o. Refusal of certain transfers.*

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

*p. Advance directives.*

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident'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 nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

**81.13(6)** *Admission, transfer and discharge rights.*

*a. Transfer and discharge.*

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident, the resident's case manager for those residents enrolled with a managed care organization and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall include the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

*b. Notice of bed-hold policy and readmission.*

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

*c. Equal access to quality care.*

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)“a”(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

*d. Admissions policy.*

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)“a,” and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

**81.13(7) Resident behavior and facility practices.**

*a. Restraints.* The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

*b. Abuse.* The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

*c. Staff treatment of residents.* The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

\* (1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

\*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

**81.13(8) Quality of life.** A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

*a. Dignity.* The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

*b. Self-determination and participation.* The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

*c. Participation in resident and family groups.*

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

*d. Participation in other activities.* A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

*e. Accommodation of needs.* A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

*f. Activities.*

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

*g. Social services.*

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

*h. Environment.* The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

**81.13(9) Resident assessment.** The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

*a. Admission orders.* At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

*b. Comprehensive assessments.*

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.

2. Customary routine.

3. Cognitive patterns.

4. Communication.
  5. Vision.
  6. Mood and behavior patterns.
  7. Psychosocial well-being.
  8. Physical functioning and structural problems.
  9. Continence.
  10. Disease diagnoses and health conditions.
  11. Dental and nutritional status.
  12. Skin condition.
  13. Activity pursuit.
  14. Medications.
  15. Special treatments and procedures.
  16. Discharge potential.
  17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
  18. Documentation of participation in assessment.
  19. Additional specification relating to resident status as required in Section S of the MDS.
- (3) Frequency. Assessments shall be conducted:
1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
  2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.
  3. In no case less often than once every 12 months.
- (4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.
- (5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.
- (6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.
- (7) Automated data processing requirement.
1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.
    - Admission assessment.
    - Annual assessment updates.
    - Significant change in status assessments.
    - Quarterly review assessments.
    - A subset of items upon a resident's transfer, reentry, discharge, and death.
    - Background (face sheet) information, if there is no admission assessment.
  2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the ASCII format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

*c. Accuracy of assessments.* The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

*d. Comprehensive care plans.*

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph "b," subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's case manager as appropriate and as allowed by the resident for those residents enrolled with a managed care organization, and the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

*e. Discharge summary.* When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph "b," subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

*f. Preadmission screening for mentally ill individuals and individuals with mental retardation.* Rescinded IAB 9/7/11, effective 9/1/11.

*g. Preadmission resident assessment.* The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

**81.13(10) Quality of care.** Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

*a. Activities of daily living.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

*b. Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

*c. Pressure sores.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

*d. Urinary incontinence.* Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

*e. Range of motion.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

*f. Mental and psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

*g. Naso-gastric tubes.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

*h. Accidents.* The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

*i. Nutrition.* Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

*j. Hydration.* The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

*k. Special needs.* The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections.

(2) Parenteral and enteral fluids.

(3) Colostomy, ureterostomy or ileostomy care.

(4) Tracheostomy care.

(5) Tracheal suctioning.

(6) Respiratory care.

(7) Foot care.

(8) Prostheses.

*l. Unnecessary drugs.*

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or

2. For excessive duration; or

3. Without adequate monitoring; or

4. Without adequate indications for its use; or

5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

*m. Medication errors.* The facility shall ensure that:

(1) It is free of significant medication error rates of 5 percent or greater.

(2) Residents are free of any significant medication errors.

**81.13(11) Nursing services.** The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

*a. Sufficient staff.*

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph “c,” licensed nurses.

2. Other nursing personnel.

(2) Except when waived under paragraph “c,” the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

*b. Registered nurse.*

(1) Except when waived under paragraph “c,” the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(2) Except when waived under paragraph “c,” the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

*c. Nursing facilities.* Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph “b,” or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph “a,” if the following conditions are met:

(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(4) A waiver granted under the conditions listed in paragraph “c” is subject to annual department of inspections and appeals review.

(5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

(6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

**81.13(12) Dietary services.** The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

*a. Staffing.* The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

*b. Sufficient staff.* The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

*c. Menus and nutritional adequacy.* Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

*d. Food.* Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

*e. Therapeutic diets.* Therapeutic diets shall be prescribed by the attending physician.

*f. Frequency of meals.*

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

*g. Assistive devices.* The facility shall provide special eating equipment and utensils for residents who need them.

*h. Sanitary conditions.* The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

**81.13(13) Physician services.** A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

*a. Physician supervision.* The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

*b. Physician visits.* The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph "c" below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

*c. Frequency of physician visits.*

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph "e," all required physician visits shall be made by the physician personally.

*d. Availability of physicians for emergency care.* The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

*e. Performance of physician tasks in nursing facilities.* Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

**81.13(14) Specialized services.** When indicated, specialized services shall be provided to residents as follows:

*a. Specialized rehabilitative services.* Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident's comprehensive plan of care, the facility shall:

- (1) Provide the required services; or
- (2) Obtain the required services from an outside provider of specialized rehabilitative services.

*b. Specialized services for mental illness.* "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) May be provided only by a specialized licensed or certified practitioner;

- (5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and

- (6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service which is available through the Iowa plan for behavioral health and for which the member meets eligibility criteria.

*c. Specialized services for intellectual disability.* "Specialized services for intellectual disability" means services that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;

- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) Must be supervised by a qualified intellectual disability professional; and

- (5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

**81.13(15) Dental services.** The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

*a.* Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

- (1) Routine dental services to the extent covered under the state plan.
- (2) Emergency dental services.

*b.* If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office.

*c.* Promptly refer residents with lost or damaged dentures to a dentist.

**81.13(16) Pharmacy services.** The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

*a. Procedures.* A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

*b. Service consultation.* The facility shall employ or obtain the services of a licensed pharmacist who:

- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility.
- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
- (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

*c. Drug regimen review.*

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

*d. Labeling of drugs and biologicals.* Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

*e. Storage of drugs and biologicals.*

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

*f. Consultant pharmacists.* When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

**81.13(17) Infection control.** The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. *Infection control program.* The facility shall establish an infection control program under which it:

- (1) Investigates, controls and prevents infections in the facility.
- (2) Decides what procedures, such as isolation, should be applied to an individual resident.
- (3) Maintains a record of incidents and corrective actions related to infections.

b. *Preventing spread of infection.*

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. *Linens.* Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

**81.13(18) Physical environment.** The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. *Life safety from fire.* Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. *Emergency power.*

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. *Space and equipment.* The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. *Resident rooms.* Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

(1) Bedrooms shall:

1. Accommodate no more than four residents.

2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

3. Have direct access to an exit corridor.

4. Be designed or equipped to ensure full visual privacy for each resident.

5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.

7. Have a floor at or above grade level.

(2) The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph "d," subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

*e. Toilet facilities.* Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

*f. Resident call system.* The nurse's station shall be equipped to receive resident calls through a communication system from:

(1) Resident rooms.

(2) Toilet and bathing facilities.

*g. Dining and resident activities.* The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

(1) Be well lighted.

(2) Be well ventilated, with nonsmoking areas identified.

(3) Be adequately furnished.

(4) Have sufficient space to accommodate all activities.

*h. Other environmental conditions.* The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

(2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.

(3) Equip corridors with firmly secured handrails on each side.

(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

**81.13(19) Administration.** A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

*a. Licensure.* A facility shall be licensed under applicable state and federal law.

*b. Compliance with federal, state and local laws and professional standards.* The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

*c. Relationship to other Department of Health and Human Services (HHS) regulations.* In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

*d. Governing body.*

(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(2) The governing body appoints the administrator who is:

1. Licensed by the state.
2. Responsible for management of the facility.

*e. Required training of nurse aides.*

(1) Definitions.

“*Licensed health professional*” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“*Nurse aide*” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.
2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;
2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or
3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or
2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

*f. Proficiency of nurse aides.* The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

*g. Staff qualifications.*

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

*h. Use of outside resources.*

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

*i. Medical director.*

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

*j. Laboratory services.*

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

*k. Radiology and other diagnostic services.*

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

- (2) The facility shall:
  1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.
  2. Promptly notify the attending physician of the findings.
  3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.
  4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.
    - l. *Clinical records.*
      - (1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.
      - (2) Clinical records shall be retained for:
        1. The period of time required by state law.
        2. Five years from the date of discharge when there is no requirement in state law.
        3. For a minor, three years after a resident reaches legal age under state law.
      - (3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.
      - (4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:
        1. Transfer to another health care institution.
        2. Law.
        3. Third-party payment contract.
        4. The resident.
      - (5) The clinical record shall contain:
        1. Sufficient information to identify the resident.
        2. A record of the resident's assessments.
        3. The plan of care and services provided.
        4. The results of any preadmission screening conducted by the state.
        5. Progress notes.
      - m. *Disaster and emergency preparedness.*
        - (1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.
        - (2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.
      - n. *Transfer agreement.*
        - (1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:
          1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
          2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.
        - (2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
      - o. *Quality assessment and assurance.*
        - (1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.

- (2) The quality assessment and assurance committee:
  1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
  2. Develops and implements appropriate plans of action to correct identified quality deficiencies.
- (3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.
- (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
  - p. Disclosure of ownership.*
    - (1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.
    - (2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:
      1. Persons with an ownership or control interest.
      2. The officers, directors, agents, or managing employees.
      3. The corporation, association, or other company responsible for the management of the facility.
      4. The facility's administrator or director of nursing.
    - (3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—81.14(249A) Audits.**

**81.14(1) *Audit of financial and statistical report.*** Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

*a.* When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

*b.* When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

#### **81.14(2) *Audit of proper billing and handling of patient funds.***

*a.* The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals, and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

*b.* The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph “d,” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a” and 249A.4.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—81.15(249A) Nurse aide training and testing programs.** Rescinded IAB 12/9/92, effective 2/1/93.

**441—81.16(249A) Nurse aide requirements and training and testing programs.**

**81.16(1) Deemed meeting of requirements.** A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the department of inspections and appeals if the nurse aide successfully completed a training and competency evaluation program before July 1, 1989. The aide would have satisfied this requirement if:

- a. At least 60 hours were substituted for 75 hours; and
- b. The aide has made up at least the difference in the number of hours in the program the aide completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse education; or
- c. The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 hours’ duration; or
- d. The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989; or
- e. The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered.

**81.16(2) State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.**

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) “e” and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).
2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2) “f,” the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or
  3. Has been assessed a civil money penalty of not less than \$5,000; or
  4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or
  5. Pursuant to state action, was closed or had its residents transferred; or
  6. Has been terminated from participation in the Medicaid or Medicare program; or
  7. Has been denied payment under subrule 81.40(1) or 81.40(2).
- (3) Rescinded IAB 10/7/98, effective 12/1/98.

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

- (1) Advise the requester whether or not the program has been approved; or
- (2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2) "b"(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

f. An exception to subparagraph 81.16(2) "b"(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

**81.16(3)** *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and testing programs. Policies and procedures governing approval of the programs are set forth in these rules.

a. For a nurse aide training and competency evaluation program to be approved by the department of inspections and appeals, it shall, at a minimum:

(1) Consist of no less than 75 clock hours of training.

(2) Include at least the subjects specified in 81.16(3).

(3) Include at least 15 hours of laboratory experience, 30 hours of classroom instruction (the first 16 hours of which must occur before the nurse aide has resident contact) and 30 hours of supervised clinical training. Supervised clinical training means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

(4) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor. It shall also ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.

(5) Meet the following requirements for instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of qualified trainers to students shall not exceed one instructor for every ten students in the clinical setting.

(6) Contain information regarding competency evaluation through written or oral and skills testing.

b. The curriculum of the nurse aide training program shall include:

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

1. Communication and interpersonal skills.

2. Infection control.

3. Safety and emergency procedures including the Heimlich maneuver.

4. Promoting residents' independence.

5. Respecting residents' rights.

(2) Basic nursing skills:

1. Taking and recording vital signs.

2. Measuring and recording height and weight.

3. Caring for the residents' environment.

4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.

5. Caring for residents when death is imminent.
- (3) Personal care skills, including, but not limited to:
  1. Bathing.
  2. Grooming, including mouth care.
  3. Dressing.
  4. Toileting.
  5. Assisting with eating and hydration.
  6. Proper feeding techniques.
  7. Skin care.
  8. Transfers, positioning, and turning.
- (4) Mental health and social service needs:
  1. Modifying aide's behavior in response to residents' behavior.
  2. Awareness of developmental tasks associated with the aging process.
  3. How to respond to resident behavior.
  4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.
  5. Using the resident's family as a source of emotional support.
- (5) Care of cognitively impaired residents:
  1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).
  2. Communicating with cognitively impaired residents.
  3. Understanding the behavior of cognitively impaired residents.
  4. Appropriate responses to the behavior of cognitively impaired residents.
  5. Methods of reducing the effects of cognitive impairments.
- (6) Basic restorative services:
  1. Training the resident in self-care according to the resident's ability.
  2. Use of assistive devices in transferring, ambulation, eating and dressing.
  3. Maintenance of range of motion.
  4. Proper turning and positioning in bed and chair.
  5. Bowel and bladder training.
  6. Care and use of prosthetic and orthotic devices.
- (7) Residents' rights:
  1. Providing privacy and maintenance of confidentiality.
  2. Promoting the residents' rights to make personal choices to accommodate their needs.
  3. Giving assistance in resolving grievances and disputes.
  4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
  5. Maintaining care and security of residents' personal possessions.
  6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
  7. Avoiding the need for restraints in accordance with current professional standards.
- c. Prohibition of charges.
  - (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may be charged for any portion of the program including any fees for textbooks or other required evaluation or course materials.
  - (2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

1. Add all costs incurred by the aides for the course, books, and tests.
2. Divide the total arrived at in No. 1 above by 12 to prorate the costs over a one-year period and establish a monthly rate.
3. The aide shall be reimbursed the monthly rate each month the aide works at the facility until one year from the time the aide completed the course.
- d.* Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.
- e.* Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:
  - (1) Notify the department of inspections and appeals:
    1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.
    2. When a facility or other training entity will no longer be offering nurse aide training courses.
    3. Whenever the person coordinating the training program is hired or terminates employment.
  - (2) Keep a list of faculty members and their qualifications available for department review.
  - (3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
  - (4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.
  - (5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

**81.16(4) Nurse aide competency evaluation.** A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.

*a.* Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.

*b.* Content of the competency evaluation program.

- (1) Written or oral examinations. The competency evaluation shall:
  1. Allow an aide to choose between a written and oral examination.
  2. Address each of the course requirements listed in 81.16(3) "b."
  3. Be developed from a pool of test questions, only a portion of which is used in any one examination.
  4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.
  5. If oral, be read from a prepared text in a neutral manner.
  6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.
  7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).

*c.* Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c."

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

*d.* Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

*e.* Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

*f.* Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

*g.* Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

*h.* Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

**81.16(5)** *Registry of nurse aides.*

*a.* Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5) "c."

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

*b.* Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.
3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

*c. Registry content.*

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

*d. Disclosure of information.* The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5) "c"(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

*e. Placement of names on nurse aide registry.* The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

**81.16(6) Hearing.** When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

**81.16(7) Appeals.** Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

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

**441—81.17(249A) Termination procedures.** Rescinded IAB 5/10/95, effective 7/1/95.

**441—81.18(249A) Sanctions.**

**81.18(1) Penalty for falsification of a resident assessment.** An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than \$100 or more than \$1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than \$500 nor more than \$5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

*a.* Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director's designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

- (1) The number of assessments willingly and knowingly falsified.
- (2) The history of the individual relative to previous assessment falsifications.
- (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
- (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.
- (5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

*b.* Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

*c.* Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

**81.18(2) Use of independent assessors.** If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

*a.* Criteria used to determine the need for independent assessors shall include:

- (1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.
- (2) The facility's response to the falsification of or causing resident assessments to be falsified.
- (3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

*b.* The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

*c.* The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

*d.* Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

*e.* Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

*f.* Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

**81.18(3)** *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

**81.18(4)** *Failure to meet requirements for participation.* Rescinded IAB 5/10/95, effective 7/1/95.

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

**441—81.19(249A) Criteria related to the specific sanctions.** Rescinded IAB 5/10/95, effective 7/1/95.

**441—81.20(249A) Out-of-state facilities.** Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

**81.20(1) Out-of-state providers.** Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit

pursuant to subparagraph 81.6(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)“f”(1), whichever is lower.

*a.* Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

*b.* Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

**81.20(2)** Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

**81.20(3)** Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

**81.20(4)** Rescinded IAB 3/20/91, effective 3/1/91.

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

[ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—81.21(249A) Outpatient services.** Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph “i.”

**441—81.22(249A) Rates for Medicaid eligibles.**

**81.22(1) Maximum client participation.** A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

**81.22(2) Beginning date of payment.** When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident’s Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident’s client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

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

[ARC 1806C, IAB 1/7/15, effective 3/1/15]

**441—81.23(249A) State-funded personal needs supplement.** A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

**441—81.24 to 81.30** Reserved.

DIVISION II  
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

**441—81.31(249A) Definitions.**

“*CMS*” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“*Deficiency*” means a nursing facility’s failure to meet a participation requirement.

“*Department*” means the Iowa department of human services.

“*Immediate jeopardy*” means a situation in which immediate corrective action is necessary because the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“*New admission*” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“*Noncompliance*” means any deficiency that causes a facility to not be in substantial compliance.

“*Plan of correction*” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“*Standard survey*” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“*Substandard quality of care*” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“*Substantial compliance*” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“*Temporary management*” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

**441—81.32(249A) General provisions.**

**81.32(1) Purpose of remedies.** The purpose of remedies is to ensure prompt compliance with program requirements.

**81.32(2) Basis for imposition and duration of remedies.** The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

**81.32(3) Number of remedies.** The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

**81.32(4) Plan of correction requirement.**

*a.* Except as specified in paragraph “*b*,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

*b.* A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

**81.32(5) Disagreement regarding remedies.** If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

**81.32(6) Notification requirements.**

*a.* The department of inspections and appeals shall give the provider written notice of remedy, including the:

- (1) Nature of the noncompliance.
- (2) Which remedy is imposed.
- (3) Effective date of the remedy.
- (4) Right to appeal the determination leading to the remedy.

*b.* Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

*c.* Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

*d.* The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

*e.* For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

*f.* For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

**81.32(7) Informal dispute resolution.**

*a.* Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility’s request, to dispute survey findings upon the facility’s receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility’s request, to dispute survey findings upon the facility’s receipt of the official statement of deficiencies.

*b.* Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

c. If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

d. Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

**441—81.33(249A) Factors to be considered in selecting remedies.**

**81.33(1) Initial assessment.** In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

**81.33(2) Determining seriousness of deficiencies.** To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

a. Whether a facility's deficiencies constitute:

- (1) No actual harm with a potential for minimal harm.
- (2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.
- (3) Actual harm that is not immediate jeopardy.
- (4) Immediate jeopardy to resident health or safety.

b. Whether the deficiencies:

- (1) Are isolated.
- (2) Constitute a pattern.
- (3) Are widespread.

**81.33(3) Other factors which may be considered in choosing a remedy within a remedy category.** Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.

b. The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

**441—81.34(249A) Available remedies.** In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

**441—81.35(249A) Selection of remedies.**

**81.35(1) Categories of remedies.** Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

**81.35(2) Application of remedies.** After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3) "a," 81.35(4) "a," and 81.35(5) "a," for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3) "b," 81.35(4) "b," and 81.35(5) "b," as applicable.

**81.35(3) Category 1.**

a. Category 1 remedies include the following:

- (1) Directed plan of correction.

- (2) State monitoring.
- (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

- (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

**81.35(4) Category 2.**

a. Category 2 remedies include the following:

- (1) Denial of payment for new admissions.
- (2) Civil money penalties of \$50 to \$3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

- (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

**81.35(5) Category 3.**

a. Category 3 remedies include the following:

- (1) Temporary management.
- (2) Immediate termination.
- (3) Civil money penalties of \$3,050 to \$10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

- (1) Temporary management.
- (2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of \$3,050 to \$10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

**81.35(6) Plan of correction.**

a. Except as specified in paragraph "b," each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

- (1) Which remedies are applied.
- (2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

**81.35(7) Appeal of a determination of noncompliance.**

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

*b.* A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

*c.* A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

*d.* Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

**441—81.36(249A) Action when there is immediate jeopardy.**

**81.36(1)** *Terminate agreement or appoint temporary manager.* If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

*a.* The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

*b.* If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

*c.* If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

*d.* The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

**81.36(2)** *Other remedies.* The department of inspections and appeals may also impose other remedies, as appropriate.

**81.36(3)** *Notification of CMS.* In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility's noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

**81.36(4)** *Transfer of residents.* The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

**81.36(5)** *Notification of physicians and state board.* If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

**441—81.37(249A) Action when there is no immediate jeopardy.**

**81.37(1)** *Termination of agreement or limitation of participation.* If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

*a.* The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;

*b.* The department of inspections and appeals has submitted a plan of correction approved by CMS; and

*c.* The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

**81.37(2) Termination.** If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

**81.37(3) Denial of payment.** Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

**81.37(4) Failure to comply.** The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

**441—81.38(249A) Action when there is repeated substandard quality of care.**

**81.38(1) General.** If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).

b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

**81.38(2) Repeated noncompliance.** For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

**81.38(3) Standard surveys to which this provision applies.** Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

**81.38(4) Program participation.**

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

(1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

**81.38(5) Compliance.** Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

(1) Alleges correction of the deficiencies cited in the most recent standard survey; or

(2) Achieves compliance before the effective date of the remedies.

**441—81.39(249A) Temporary management.** The department of inspections and appeals may appoint a temporary manager from qualified applicants.

**81.39(1) Qualifications.** The temporary manager must:

a. Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.

b. Not have been found guilty of misconduct by any licensing board or professional society in any state.

c. Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.

d. Not currently serve or, within the past two years, have served as a member of the staff of the facility.

**81.39(2) *Payment of salary.*** The temporary manager's salary:

a. Is paid directly by the facility while the temporary manager is assigned to that facility.

b. Shall be at least equivalent to the sum of the following:

(1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.

(2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.

(3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.

c. May exceed the amount specified in paragraph "b" if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

**81.39(3) *Failure to relinquish authority to temporary management.***

a. If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).

b. A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

**81.39(4) *Duration of temporary management.*** Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

#### **441—81.40(249A) Denial of payment for all new admissions.**

**81.40(1) *Optional denial of payment.*** Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

**81.40(2) *Required denial of payment.*** Payment for all new admissions shall be denied when:

a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or

b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

**81.40(3) *Resumption of payments.*** Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

**81.40(4) *Resumption of payments.*** No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

**81.40(5) *Restriction.*** No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

#### **441—81.41(249A) Secretarial authority to deny all payments.**

**81.41(1) *CMS option to deny all payment.*** If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

**81.41(2) Resumption of payment.** When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

**441—81.42(249A) State monitoring.**

**81.42(1) State monitor.** A state monitor:

- a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.
- b. Is an employee or a contractor of the department of inspections and appeals.
- c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.
- d. Is not an employee of the facility.
- e. Does not function as a consultant to the facility.
- f. Does not have an immediate family member who is a resident of the facility to be monitored.

**81.42(2) Use of state monitor.** A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

**81.42(3) Discontinuance of state monitor.** State monitoring is discontinued when:

- a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.
- b. Termination procedures are completed.

**441—81.43(249A) Directed plan of correction.** The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

**441—81.44(249A) Directed in-service training.**

**81.44(1) Required training.** The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

- a. The facility has a pattern of deficiencies that indicate noncompliance; and
- b. Education is likely to correct the deficiencies.

**81.44(2) Action following training.** After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

**81.44(3) Payment.** The facility is responsible for the payment for the directed in-service training.

**441—81.45(249A) Closure of a facility or transfer of residents, or both.**

**81.45(1) Closure during an emergency.** In an emergency, the department and the department of inspections and appeals have the authority to:

- a. Transfer Medicaid and Medicare residents to another facility; or
- b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

**81.45(2) Required transfer in immediate jeopardy situations.** When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

**81.45(3) All other situations.** Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

**441—81.46(249A) Civil money penalties—basis for imposing penalty.** The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

**441—81.47(249A) Civil money penalties—when penalty is collected.**

**81.47(1) *When facility requests a hearing.***

*a.* A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

*b.* If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

**81.47(2) *When facility does not request a hearing.*** If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

- a.* Achieves substantial compliance; or
- b.* Is terminated.

**81.47(3) *When facility waives a hearing.*** If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

- a.* Achieves substantial compliance; or
- b.* Is terminated.

**81.47(4) *Accrual and computation of penalties.*** Accrual and computation of penalties for a facility that:

- a.* Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);
- b.* Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

**81.47(5) *Collection.*** The collection of civil money penalties is made as provided in rule 441—81.52(249A).

**441—81.48(249A) Civil money penalties—notice of penalty.** The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

**441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.**

**81.49(1) *Waiver of a hearing.*** The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

**81.49(2) *Reduction of penalty amount.***

*a.* If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

*b.* If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

**441—81.50(249A) Civil money penalties—amount of penalty.**

**81.50(1) Amount of penalty.** The penalties are within the following ranges, set at \$50 increments:

a. Upper range—\$3,050 to \$10,000. Penalties in the range of \$3,050 to \$10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) “b.”

b. Lower range—\$50 to \$3,000. Penalties in the range of \$50 to \$3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

**81.50(2) Basis for penalty amount.** The amount of penalty is based on the department of inspections and appeals’ assessment of factors listed in subrule 81.50(6).

**81.50(3) Decreased penalty amounts.** Except as specified in 81.50(4) “b,” if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

**81.50(4) Increased penalty amounts.**

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

**81.50(5) Review of the penalty.** When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

a. Set a penalty of zero or reduce a penalty to zero.

b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.

c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

**81.50(6) Factors affecting the amount of penalty.** In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

a. The facility’s history of noncompliance, including repeated deficiencies.

b. The facility’s financial condition.

c. The factors specified in rule 441—81.33(249A).

d. The facility’s degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

**81.50(7) Authority to settle penalties.** The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

**441—81.51(249A) Civil money penalties—effective date and duration of penalty.**

**81.51(1) When penalty begins to accrue.** The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

**81.51(2) Duration of penalty.** The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

a. The department of inspections and appeals’ decision of noncompliance is upheld after a final administrative decision;

b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or

c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

**81.51(3) *Penalty due.*** The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

**81.51(4) *Notice after facility achieves compliance.*** When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

- a. The amount of penalty per day;
- b. The number of days involved;
- c. The total amount due;
- d. The due date of the penalty; and
- e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

**81.51(5) *Notice to terminated facility.*** In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

- a. Final administrative decision is made;
- b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or
- c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

**81.51(6) *Accrual of penalties when there is no immediate jeopardy.***

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph “a,” if the facility has not achieved substantial compliance, the provider agreement may be terminated.

**81.51(7) *Accrual of penalties when there is immediate jeopardy.***

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

**81.51(8) *Documenting substantial compliance.***

a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

#### **441—81.52(249A) Civil money penalties—due date for payment of penalty.**

**81.52(1) *When payments are due.***

a. A civil money penalty payment is due 15 days after a final administrative decision is made when:

- (1) The facility achieves substantial compliance before the final administrative decision; or
- (2) The effective date of termination occurs before the final administrative decision.

b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

- (1) The facility achieves substantial compliance before the hearing request was due; or
- (2) The effective date of termination occurs before the hearing request was due.

c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

(1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or

(2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

*d.* A civil money penalty payment is due 15 days after substantial compliance is achieved when:

- (1) The final administrative decision is made before the facility came into compliance;
- (2) The facility did not file a timely hearing request before it came into substantial compliance; or
- (3) The facility waived its right to a hearing before it came into substantial compliance.

*e.* A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

- (1) The final administrative decision was made;
- (2) The time for requesting a hearing has expired and the facility did not request a hearing; or
- (3) The facility waived its right to a hearing.

*f.* In the cases specified in paragraph “*d.*,” the period of noncompliance may not extend beyond six months from the last day of the survey.

**81.52(2) *Deduction of penalty from amount owed.*** The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

**81.52(3) *Interest.*** Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

**81.52(4) *Penalties collected by the department.*** Rescinded IAB 3/9/11, effective 4/1/11.  
[ARC 9402B, IAB 3/9/11, effective 4/1/11]

**441—81.53(249A) Use of penalties collected by the department.** Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Payment for the cost of relocating residents to other facilities;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents; and
4. Funding of projects to improve the quality of life or quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

**441—81.54(249A) Continuation of payments to a facility with deficiencies.**

**81.54(1) *Criteria.***

*a.* The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

- (1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;
- (2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and
- (3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

*b.* The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1) “*a*” are not met.

**81.54(2) *Cessation of payments.*** If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1) “*a*” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

**81.54(3) *Period of continued payments.*** If the conditions in 81.54(1) “*a*” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

**81.54(4) Failure to achieve substantial compliance.** If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

**441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy.** This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

**81.55(1) Disagreement over whether facility has met requirements.**

*a.* The department of inspections and appeals' finding of noncompliance takes precedence when:

- (1) CMS finds the facility is in substantial compliance with the participation requirements; and
- (2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

*b.* CMS's findings of noncompliance take precedence when:

- (1) CMS finds that a facility has not achieved substantial compliance; and
- (2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

*c.* When CMS's survey findings take precedence, CMS may:

- (1) Impose any of the alternative remedies specified in rule 441—81.34(249A);
- (2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and
- (3) Stop federal financial participation to the department for a nursing facility.

**81.55(2) Disagreement over decision to terminate.**

*a.* CMS's decision to terminate the participation of a facility takes precedence when:

- (1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and
- (2) CMS, but not the department of inspections and appeals, finds that the facility's participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

*b.* The department of inspections and appeals' decision to terminate a facility's participation and the procedures for appealing the termination take precedence when:

- (1) The department of inspections and appeals, but not CMS, finds that a facility's participation should be terminated; and
- (2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

**81.55(3) Disagreement over timing of termination of facility.** The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

*a.* A facility is not in substantial compliance; and

*b.* The facility's participation should be terminated.

**81.55(4) Disagreement over remedies.**

*a.* When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

- (1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and
- (2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

*b.* When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

**81.55(5) One decision.** Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid

agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

**441—81.56(249A) Duration of remedies.**

**81.56(1) Remedies continue.** Except as specified in subrule 81.56(2), alternative remedies continue until:

- a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or
- b. The provider agreement is terminated.

**81.56(2) State monitoring.** In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

- a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or
- b. The provider agreement is terminated.

**81.56(3) Temporary management.** In the case of temporary management, the remedy continues until:

- a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;
- b. The provider agreement is terminated; or
- c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

**81.56(4) Facility in compliance.** If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

**441—81.57(249A) Termination of provider agreement.**

**81.57(1) Effect of termination.** Termination of the provider agreement ends payment to the facility and any alternative remedy.

**81.57(2) Basis of termination.**

- a. A facility's provider agreement may be terminated if a facility:
  - (1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or
  - (2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.
- b. A facility's provider agreement shall be terminated if a facility:
  - (1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or
  - (2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1)“a.”

**81.57(3) Notice of termination.** Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

- a. At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and
- b. At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

These rules are intended to implement Iowa Code section 249A.4.

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<sup>1</sup> Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.

<sup>2</sup> Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.

- <sup>3</sup> Effective date of 81.13(7) "c"(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
- <sup>4</sup> Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
- <sup>5</sup> 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**.

## OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.



CHAPTER 82  
INTERMEDIATE CARE FACILITIES FOR PERSONS  
WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 82]

[Prior to 2/11/87, Human Services[498]]

**441—82.1(249A) Definition.**

*“Department”* means the Iowa department of human services.

*“Intermediate care facility for persons with an intellectual disability (ICF/ID)”* means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Managed care organization”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

This rule is intended to implement Iowa Code section 249A.12.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—82.2(249A) Licensing and certification.** In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections and appeals under the department of inspections and appeals rules found in 481—Chapter 64. The facility shall meet the following conditions of participation:

**82.2(1) Governing body and management.**

*a. Governing body.* The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- (1) Exercise general policy, budget, and operating direction over the facility.
- (2) Set the qualifications (in addition to those already set by state law) for the administrator of the facility.

- (3) Appoint the administrator of the facility.

*b. Compliance with federal, state, and local laws.* The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation.

*c. Client records.*

- (1) The facility shall develop and maintain a record-keeping system that includes a separate record for each client and that documents the clients’ health care, active treatment, social information, and protection of the client’s rights.

- (2) The facility shall keep confidential all information contained in the clients’ records, regardless of the form or storage method of the records.

- (3) The facility shall develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if the client is a minor) or legal guardian.

- (4) Any individual who makes an entry in a client’s record shall make it legibly, date it, and sign it.

- (5) The facility shall provide a legend to explain any symbol or abbreviation used in a client’s record.

(6) The facility shall provide each identified residential living unit with appropriate aspects of each client's record.

*d. Services provided under agreements with outside sources.*

(1) If a service required under this rule is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement shall:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

2. Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this rule.

(3) The facility shall ensure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/ID, the ICF/ID remains directly responsible for the standards relating to physical environment that are specified in subrule 82.2(7), paragraphs "a" to "g," "j," and "k."

*e. Disclosure of ownership.* The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

(1) Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

(2) Each officer and director of the corporation, if the facility is organized as a corporation.

(3) Each partner, if the facility is organized as a partnership.

**82.2(2) Client protections.**

*a. Protection of clients' rights.* The facility shall ensure the rights of all clients. Therefore, the facility shall:

(1) Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility.

(2) Inform each client, parent (if the child is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

(5) Ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail.

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

(11) Ensure clients the opportunity to participate in social, religious, and community group activities.

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in the client's own clothing each day.

(13) Permit a husband and wife who both reside in the facility to share a room.

*b. Client finances.*

(1) The facility shall establish and maintain a system that ensures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients and precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record shall be available on request to the client, parents (if the client is a minor), or legal guardian.

*c. Communication with clients, parents, and guardians.* The facility shall:

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

(2) Answer communications from clients' families and friends promptly and appropriately.

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy.

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations.

(6) Notify promptly the client's parents or guardian of any significant incidents or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

*d. Staff treatment of clients.*

(1) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment.

2. Staff shall not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

3. The facility shall prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility shall ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

**82.2(3) Facility staffing.**

*a. Qualified intellectual disability professional.* Each client's active treatment program shall be integrated, coordinated and monitored by a qualified intellectual disability professional who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and is one of the following:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) An individual who holds at least a bachelor's degree in a professional category specified in 82.2(3) "b"(5).

*b. Professional program services.*

(1) Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff shall work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff shall be licensed, certified, or registered, as applicable, to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, an individual shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, an individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, an individual shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, an individual shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, an individual shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, an individual shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. To be designated as a professional dietitian, an individual shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, an individual shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling and psychology).

(6) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of 82.2(3)"b"(5) are not required except for qualified intellectual disability professionals who must meet the requirements set forth in 82.2(3)"a."

*c. Facility staffing.*

(1) The facility shall not depend upon clients or volunteers to perform direct care services for the facility.

(2) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: clients for whom a physician has ordered a medical care plan; clients who are aggressive, assaultive or security risks; more than 16 clients; or fewer than 16 clients within a multi-unit building.

(3) There shall be a responsible direct care staff person on duty on a 24-hour basis, when clients are present, to respond to injuries and symptoms of illness, and to handle emergencies, in each defined

residential living unit housing: clients for whom a physician has not ordered a medical care plan; clients who are not aggressive, assaultive or security risks; and 16 or fewer clients.

(4) The facility shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

*d. Direct care (residential living unit) staff.*

(1) The facility shall provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to clients:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly intellectually disabled clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff-to-client ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately intellectually disabled clients, the staff-to-client ratio is 1 to 4.

3. For each defined residential living unit serving clients who function within the range of mild intellectual disability, the staff-to-client ratio is 1 to 6.4.

4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.

*e. Staff training program.*

(1) The facility shall provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently.

(2) For employees who work with clients, training shall focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff shall be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff shall be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

**82.2(4) Active treatment services.**

*a. Active treatment.*

(1) Each client shall receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this paragraph, that is directed toward: the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

*b. Admissions, transfers, and discharge.*

(1) Clients who are admitted by the facility shall be in need of and receiving active treatment services.

(2) Admission decisions shall be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility shall have documentation in the client's record that the client was transferred or discharged for good cause, and shall provide a reasonable

time to prepare the client and the client's parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility shall develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies, and shall provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

*c. Individual program plan.*

(1) Each client shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs, as described by the comprehensive functional assessments required in 82.2(4) "c"(3), and designing programs that meet the client's needs.

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. For those clients enrolled with a managed care organization, the client's case manager shall participate as appropriate and as allowed by the client. Participation by the client, the client's parents (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment shall take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and shall:

1. Identify the presenting problems and disabilities and, where possible, their causes.
2. Identify the client's specific developmental strengths.
3. Identify the client's specific developmental and behavioral management needs.
4. Identify the client's need for services without regard to the actual availability of the services needed.
5. Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and, as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team shall prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by 82.2(4) "c"(3), and the planned sequence for dealing with those objectives. These objectives shall:

1. Be stated separately, in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the individual.
5. Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The methods to be used.
2. The schedule for use of the method.
3. The person responsible for the program.
4. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.
5. The inappropriate client behaviors, if applicable.
6. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan shall also:

1. Describe relevant interventions to support the individual toward independence.

2. Identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.

3. Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

4. Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

5. Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

6. Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

*d. Program implementation.*

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan shall be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

*e. Program documentation.*

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives shall be documented in measurable terms.

(2) The facility shall document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

*f. Program monitoring and change.*

(1) The individual program plan shall be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to, situations in which the client:

1. Has successfully completed an objective or objectives identified in the individual program plan.
2. Is regressing or losing skills already gained.
3. Is failing to progress toward identified objectives after reasonable efforts have been made.
4. Is being considered for training toward new objectives.

(2) At least annually, the comprehensive functional assessment of each client shall be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan shall be revised, as appropriate, repeating the process set forth in 82.2(4) "c."

(3) The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to:

1. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

2. Ensure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian.

3. Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control

of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes needs to be addressed.

(4) The provisions of 82.2(4)“f”(3) may be modified only if, in the judgment of the department of inspections and appeals, court decrees, state law or regulations provide for equivalent client protection and consultation.

**82.2(5) Client behavior and facility practices.**

*a. Facility practices—conduct toward clients.*

(1) The facility shall develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures shall:

1. Promote the growth, development and independence of the client.
2. Address the extent to which client choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible.
3. Specify client conduct to be allowed or not allowed.
4. Be available to all staff, clients, parents of minor children, and legal guardians.

(2) To the extent possible, clients shall participate in the formulation of these policies and procedures.

(3) Clients shall not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

*b. Management of inappropriate client behavior.*

(1) The facility shall develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures shall be consistent with the provisions of 82.2(5)“a.” These procedures shall:

1. Specify all facility-approved interventions to manage inappropriate client behavior.
2. Designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.
3. Ensure, prior to the use of more restrictive techniques, that the client’s record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

4. Address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.

(2) Interventions to manage inappropriate client behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

(3) Techniques to manage inappropriate client behavior shall never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.

(4) The use of systematic interventions to manage inappropriate client behavior shall be incorporated into the client’s individual program plan, in accordance with 82.2(4)“c”(4) and (5).

(5) Standing or as-needed programs to control inappropriate behavior are not permitted.

*c. Time-out rooms.*

(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

1. The placement is a part of an approved systematic time-out program as required by 82.2(5)“b.”
2. The client is under the direct constant visual supervision of designated staff.
3. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

(2) Placement of a client in a time-out room shall not exceed one hour.

(3) Clients placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

(4) A record of time-out activities shall be kept.

*d. Physical restraints.*

- (1) The facility may employ physical restraint only:
  1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.
  2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury.
  3. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.
- (2) Authorizations to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the client is restrained or stable.
- (3) The facility shall not issue orders for restraint on a standing or as-needed basis.
- (4) A client placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, shall be released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.
- (5) Restraints shall be designated and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.
- (6) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which restraint is employed, and a record of the activity shall be kept.
- (7) Barred enclosures shall not be more than three feet in height and shall not have tops.

*e. Drug usage.*

- (1) The facility shall not use drugs in doses that interfere with the individual client's daily living activities.
- (2) Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction and eventual elimination of the behaviors for which the drugs are employed.
- (3) Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.
- (4) Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirement at 82.2(6) "j," for desired responses and adverse consequences by facility staff, and shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

**82.2(6) Health care services.**

*a. Physician services.*

- (1) The facility shall ensure the availability of physician services 24 hours a day.
- (2) The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.
- (3) The facility shall provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:
  1. Evaluation of vision and hearing.
  2. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.
  3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.
  4. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.
- (4) To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this subrule.

*b. Physician participation in the individual program plan.* A physician shall participate in:

- (1) The establishment of each newly admitted client's initial individual program plan.
- (2) If appropriate, physicians shall participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

*c. Nursing services.* The facility shall provide clients with nursing services in accordance with their needs. These services shall include:

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.

(3) For those clients certified as not needing a medical care plan, a review of their health status which shall:

1. Be by a direct physical examination.
  2. Be by a licensed nurse.
  3. Be on a quarterly or more frequent basis depending on client need.
  4. Be recorded in the client's record.
  5. Result in any necessary action including referral to a physician to address client health problems.
- (4) Other nursing care as prescribed by the physician or as identified by client needs.
- (5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

1. Training clients and staff as needed in appropriate health and hygiene methods.

2. Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.

3. Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

*d. Nursing staff.*

(1) Nurses providing services in the facility shall have a current license to practice in the state.

(2) The facility shall employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

(3) The facility shall utilize registered nurses as appropriate and required by state law to perform the health services specified in this subrule.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse.

(5) Nonlicensed nursing personnel who work with clients under a medical care plan shall do so under the supervision of licensed persons.

*e. Dental services.*

(1) The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals shall participate in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility shall provide education and training in the maintenance of oral health.

*f. Comprehensive dental diagnostic services.* Comprehensive dental diagnostic services include:

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility unless the examination was completed within 12 months before admission.

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease.

(3) A review of the results of examination and entry of the results in the client's dental record.

*g. Comprehensive dental treatment.* The facility shall ensure comprehensive dental treatment services that include:

- (1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.
- (2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

*h. Documentation of dental services.*

- (1) If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.
- (2) If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

*i. Pharmacy services.* The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

*j. Drug regimen review.*

- (1) A pharmacist with input from the interdisciplinary team shall review the drug regimen of each client at least quarterly.
- (2) The pharmacist shall report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.
- (3) The pharmacist shall prepare a record of each client's drug regimen reviews and the facility shall maintain that record.
- (4) An individual medication administration record shall be maintained for each client.
- (5) As appropriate, the pharmacist shall participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

*k. Drug administration.* The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. The system shall ensure that:

- (1) All drugs are administered in compliance with the physician's orders.
- (2) All drugs, including those that are self-administered, are administered without error.
- (3) Unlicensed personnel are allowed to administer drugs only if state law permits.
- (4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.
- (5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client.
- (6) No client self-administers medications until the client demonstrates the competency to do so.
- (7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with state law.
- (8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

*l. Drug storage and record keeping.*

- (1) The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security.
- (2) The facility shall keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self-administer drugs in accordance with 82.2(6) "k"(4) may have access to keys to their individual drug supply.
- (3) The facility shall maintain records of the receipt and disposition of all controlled drugs.
- (4) The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in Schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.).
- (5) If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

*m. Drug labeling.*

(1) Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client shall be immediately removed from the client's current medication supply if discontinued by the physician.

*n. Laboratory services.*

(1) For purposes of this subrule, "laboratory" means an entity for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801.

(4) The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

**82.2(7) Physical environment.**

*a. Client living environment.*

(1) The facility shall not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

*b. Client bedrooms.*

(1) Bedrooms shall:

1. Be rooms that have at least one outside wall.

2. Be equipped with or located near toilet and bathing facilities.

3. Accommodate no more than four clients unless granted a variance under 82.2(7) "b"(3).

4. Measure at least 60 square feet per client in multiple-client bedrooms and at least 80 square feet in single-client bedrooms.

5. In all facilities initially certified or in buildings constructed or with major renovations or conversions, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the client occupying the rooms and shall be no more than 44 inches measured to the windowsill above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life

Safety Code, in which case the window must be no more than 36 inches measured to the windowsill above the floor.

(3) The department of inspections and appeals may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disability professional certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.

(4) The facility shall provide each client with:

1. A separate bed of proper size and height for the convenience of the client.
2. A clean, comfortable mattress.
3. Bedding appropriate to the weather and climate.
4. Functional furniture appropriate to the client's needs, and individual closet space in the client's

bedroom with clothes racks and shelves accessible to the client.

*c. Storage space in bedroom.* The facility shall provide:

(1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.

(2) Suitable storage space, accessible to clients, for personal possessions such as televisions, radios, prosthetic equipment and clothing.

*d. Client bathrooms.* The facility shall:

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.

(2) Provide for individual privacy in toilets, bathtubs, and showers.

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

*e. Heating and ventilation.*

(1) Each client bedroom in the facility shall have at least one window to the outside and direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

*f. Floors.* The facility shall have:

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.

(2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor.

(3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.

*g. Space and equipment.* The facility shall:

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this rule and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

*h. Emergency plan and procedures.*

(1) The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

*i. Evacuation drills.*

(1) The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility shall actually evacuate clients during at least one drill each year on each shift; make special provisions for the evacuation of clients with physical disabilities; file a report and evaluation on each evacuation drill; and investigate all problems with evacuation drills, including accidents, and take corrective action. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities shall meet the requirements of 82.2(7) "i"(1) and (2) for any live-in and relief staff they utilize.

*j. Fire protection.*

(1) General.

1. Except as specified in 82.2(7) "i"(2), the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

2. The department of inspections and appeals may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

3. A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) Exceptions.

1. For facilities that meet the LSC definition of a health care occupancy, the Centers for Medicare and Medicaid Services may waive, for a period it considers appropriate, specific provisions of the LSC if the waiver would not adversely affect the health and safety of the clients and rigid application of specific provisions would result in an unreasonable hardship for the facility.

The department of inspections and appeals may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's clients.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the code.

2. For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the department of inspections and appeals may apply the state's fire and safety code as specified above.

*k. Paint.* The facility shall:

(1) Use lead-free paint inside the facility.

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

*l. Infection control.*

(1) The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility shall implement successful corrective action in affected problem areas.

(3) The facility shall maintain a record of incidents and corrective actions related to infections.

(4) The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

**82.2(8)** *Dietetic services.*

*a. Food and nutrition services.*

(1) Each client shall receive a nourishing, well-balanced diet including modified and specially prescribed diets.

(2) A qualified dietitian shall be employed either full-time, part-time or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

*b. Meal services.*

(1) Each client shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast.

2. Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under 82.2(8) "b"(1)"1."

(2) Food shall be served:

1. In appropriate quantity.

2. At appropriate temperature.

3. In a form consistent with the developmental level of the client.

4. With appropriate utensils.

(3) Food served to clients individually and uneaten shall be discarded.

*c. Menus.*

(1) Menus shall:

1. Be prepared in advance.

2. Provide a variety of foods at each meal.

3. Be different for the same days of each week and adjusted for seasonal change.

4. Include the average portion sizes for menu items.

(2) Menus for food actually served shall be kept on file for 30 days.

*d. Dining areas and service.* The facility shall:

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician.

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each client receives enough food and to ensure that each client eats in a manner consistent with the client's developmental level.

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or physician.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability.** All intermediate care facilities for persons with an intellectual disability must

enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

**82.3(1)** *Procedures for establishing health care facilities as Title XIX facilities.* All survey procedures and the certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual."

*a.* The facility shall obtain the applicable license from the department of inspections and appeals.  
*b.* The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

*c.* The department shall transmit an application form and copies of standards to the facility.  
*d.* The facility shall complete its portion of the application form and submit it to the department.  
*e.* The department shall review the application form and forward it to the department of inspections and appeals.

*f.* The department of inspections and appeals shall schedule and complete a survey of the facility.  
*g.* The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

*h.* The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division, department of inspections and appeals. This plan must be approved before the facility can be certified.

*i.* The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

*j.* When certification is recommended, the department of inspections and appeals shall notify the department recommending terms and conditions of a provider agreement.

*k.* The department shall review the certification data and:  
(1) Transmit the provider agreement as recommended, or  
(2) Transmit the provider agreement for a term less than recommended by the department of inspections and appeals or elect not to execute an agreement for reasons of good cause as defined in 82.3(2) "c."

**82.3(2)** *Title XIX provider agreements.* The health care facility must be recommended for certification by the Iowa department of inspections and appeals for participation as an intermediate care facility for persons with an intellectual disability before a provider agreement may be issued. All survey procedures and certification processes shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

*a.* Terms of the agreement for facilities without deficiencies are as follows:  
(1) The provider agreement shall be issued for a period not to exceed 12 months.  
(2) The provider agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement for reasons of good cause, or cancel an agreement.

*b.* Terms of the agreement for facilities with deficiencies are as follows:  
(1) A new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies up to a period of 12 months.

(2) A new provider agreement may be issued for a period of up to 12 months subject to automatic cancellation 60 days following the scheduled date for correction unless required corrections have been completed or unless the survey agency finds and notifies the department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

(3) There will be no new agreement when the facility continues to be out of compliance with the same standard(s) at the end of the term of agreement.

c. The department may, for good cause, elect not to execute an agreement. Good cause shall be defined as a continued or repeated failure to operate an intermediate care facility for persons with an intellectual disability in compliance with rules and regulations of the program.

d. The department may at its option extend an agreement with a facility for two months under either of the following conditions:

(1) The health and safety of the residents will not be jeopardized thereby and the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.

(2) It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation if the extension is necessary to ensure the orderly transfer of residents.

f. When the department of inspections and appeals survey indicates deficiencies in the areas of the Life Safety Code (LSC) or environment and sanitation, a timetable detailing corrective measures shall be submitted to the department of inspections and appeals before a provider agreement can be issued. This timetable shall not exceed two years from the date of initial certification and shall detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances.

(1) The department of inspections and appeals shall determine that the facility can make corrections within the two-year period.

(2) During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

(3) The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

**82.3(3) Appeals of decertification.** A facility may appeal a decertification action according to 441—subrule 81.13(28).

This rule is intended to implement Iowa Code section 249A.12.  
[ARC 0582C, IAB 2/6/13, effective 4/1/13]

**441—82.4** Rescinded, effective March 1, 1987.

**441—82.5(249A) Financial and statistical report.** All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. These reports shall be based on the following rules.

**82.5(1) Failure to maintain records.** Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

**82.5(2) Accounting procedures.** Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

**82.5(3) Submission of reports.** The facility's cost report shall be received by the Iowa Medicaid enterprise provider cost audit and rate setting unit no later than September 30 each year except as described in subrule 82.5(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall

be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.5(3) "c."

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

d. Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

**82.5(4) *Payment at new rate.*** When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

**82.5(5) *Accrual basis.*** Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

**82.5(6) *Census of Medicaid members.*** Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

**82.5(7) *Patient days.*** In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

**82.5(8) *Opinion of accountant.*** 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 disregard of the certification and reporting instructions.

**82.5(9) *Calculating patient days.*** When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

**82.5(10) Revenues.** Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

**82.5(11) Limitation of expenses.** Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of

payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.5(3)“c.”

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary—requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.5(11)“e”(4) to 82.5(11)“e”(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

*f.* Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

*g.* Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 82.5(12).

*h.* Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

*i.* Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

*j.* A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

*k.* Each facility which supplies transportation services as defined in Iowa Code section 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, shall result in disallowance of vehicle costs and other costs associated with transporting residents.

*l.* Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

*m.* Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.
- (4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

*n.* Penalties or fines imposed by federal or state agencies are not allowable expenses.

*o.* Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

**82.5(12) Termination or change of owner.**

*a.* A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A

consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

*b.* No increase in the value of the property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

*c.* Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

*d.* In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

*e.* A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

**82.5(13) Assessed fee.** The fee assessed pursuant to 441—Chapter 36 shall be an allowable cost for cost reporting and audit purposes.

*a.* For the purpose of implementing the assessment for facilities operated by the state, Medicaid reimbursement rates shall be recalculated effective October 1, 2003, as provided in paragraph “*b.*”

*b.* For purposes of determining rates paid for services rendered after October 1, 2003, each state-operated facility’s annual costs for periods before implementation of the assessment shall be increased by an amount equal to 6 percent of the facility’s annual revenue for the preceding fiscal year.

**82.5(14) Payment to new facility.** A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, shall be subject to the provisions of this subrule.

*a.* A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility shall be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate shall be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year. The state hospital schools shall not be included in the compilation of facility costs. The beginning rates for a new facility shall be effective with the date of Medicaid certification.

*b.* Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used to adjust costs for inflation, instead of the annual percentage increase of the Consumer Price Index. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(3) All facilities shall comply with the requirements of subrule 82.5(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.5(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate shall be established for the facility. This rate shall be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the prior year's maximum allowable base cost shall be increased by 3 percent, instead of the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities shall be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/MR with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities which complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.5(14) "d," shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed

is the incentive factor. For the period beginning July 1, 2009, and ending June 30, 2010, the incentive factor shall be calculated using 3 percent in place of the percentage increase of the Consumer Price Index.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

*g.* Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates shall be subject to the prevailing maximum rate.

**82.5(15) Payment to new owner.** An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.5(16). The facility may submit a report for the period of July 1 to June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

**82.5(16) Payment to existing facilities.** The following reimbursement limits shall apply to all non-state-owned ICFs/MR:

*a.* Each facility shall file a cost report covering the period from January 1, 1992, to June 30, 1992. This cost report shall be used to establish a reimbursement rate to be paid to the facility and shall be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 to June 30.

*b.* The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, shall be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

*c.* The audited per unit cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.5(14) "d."

*d.* Facilities which have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index or of less than 3 percent for rates effective July 1, 2009, through June 30, 2010, shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year shall receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used in lieu of the percentage increase in the Consumer Price Index.

*e.* Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the

facility. Administrative costs include, but are not necessarily limited to, the administrative portion of the following:

- (1) Administrator's salary.
- (2) Assistant administrator's salary.
- (3) Bookkeeper's salary.
- (4) Other accounting and bookkeeping costs.
- (5) Other clerical salaries and clerical costs.
- (6) Administrative payroll taxes.
- (7) Administrative unemployment taxes.
- (8) Administrative group insurance.
- (9) Administrative general liability and worker's compensation insurance.
- (10) Directors' and officers' insurance or salaries.
- (11) Management fees.
- (12) Indirect business expenses and other costs related to the management of the facility including home office and other organizational costs.
- (13) Legal and professional fees.
- (14) Dues, conferences and publications.
- (15) Postage and telephone.
- (16) Administrative office supplies and equipment, including depreciation, rent, repairs, and maintenance as documented by a supplemental schedule which identifies the portion of repairs and maintenance, depreciation, and rent which applies to office supplies and equipment.
- (17) Data processing and bank charges.
- (18) Advertising.
- (19) Travel, entertainment and vehicle expenses not directly involving residents.

*f.* Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The department shall consider allowing special rate adjustments between rebasing cycles if:

- (1) An increase in the minimum wage occurs.
- (2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.
- (3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).
- (4) A facility increases or decreases licensed bed capacity by 20 percent or more.

*g.* Total patient days for purposes of the computation shall be inpatient days as determined in subrule 82.5(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate shall be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase which shall not exceed the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the inflation increase shall be 3 percent, notwithstanding the percentage change in the Consumer Price Index.

*h.* State-owned ICFs/MR shall submit semiannual cost reports and shall receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, costs of operation shall be inflated by 3 percent instead of the percentage change in the Consumer Price Index.

*i.* The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

- (1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.  
 [ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 0995C, IAB 9/4/13, effective 11/1/13]

#### **441—82.6(249A) Eligibility for services.**

**82.6(1) *Interdisciplinary team.*** The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

**82.6(2) *Evaluation.*** The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

*a.* Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

*b.* An evaluation of the resources available in the home, family, and community.

*c.* An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

*d.* An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

*e.* Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

**82.6(3) *Certification statement.*** Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility shall continue as long as a valid need for the care exists.

**82.6(4)** Rescinded IAB 4/9/97, effective 6/1/97.

This rule is intended to implement Iowa Code section 249A.12.  
 [ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—82.7(249A) Initial approval for ICF/ID care.**

**82.7(1) *Referral through targeted case management.*** Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program shall:

*a.* Identify appropriate service alternatives;

*b.* Inform the person of the alternatives; and

*c.* Refer a person without appropriate alternatives to the department.

**82.7(2) *Approval of placement by department.***

*a.* Within 30 days of receipt of a referral, the department shall:

(1) Approve ICF/ID placement;

(2) Offer a home- or community-based alternative; or

(3) Refer the person back to the targeted case management program for further consideration of service needs.

*b.* Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.7(3), the eligible person, or the person's representative, is free to seek placement in the facility

of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

**82.7(3) *Approval of level of care.*** Medicaid payment shall be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid enterprise (IME) medical services unit.

**82.7(4) *Appeal rights.*** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—82.8(249A) Determination of need for continued stay.** For clients not enrolled with a managed care organization, certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the client's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.  
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—82.9(249A) Arrangements with residents.**

**82.9(1) *Resident care agreement.*** The ICF/ID Resident Care Agreement, Form 470-0374, shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

**82.9(2) *Financial participation by resident.*** A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

**82.9(3) *Personal needs account.*** When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections and appeals and shall meet the following criteria:

*a.* Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

*b.* When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

*c.* Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

*d.* The receipts for each resident shall be kept until canceled by auditors.

*e.* The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections and appeals representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

*f.* Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department shall turn the funds over to the member's estate.

**82.9(4) *Safeguarding personal property.*** The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

*a.* Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

*b.* Providing adequate storage facilities for the resident's personal effects.

*c.* Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—82.10(249A) Discharge and transfer.**

**82.10(1) *Notice.*** When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

**82.10(2) *Case activity report.*** A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

**82.10(3) *Plan.*** The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

**82.10(4) *Transfer records.*** When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

*a.* A transfer form of diagnosis.

*b.* Aid to daily living information.

*c.* Transfer orders.

*d.* Nursing care plan.

*e.* Physician's or qualified intellectual disability professional's orders for care.

*f.* The resident's personal records.

*g.* When applicable, the personal needs fund record.

**82.10(5) *Income refund.*** When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13]

**441—82.11(249A) Continued stay review.** Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

**441—82.12(249A) Quality of care review.** Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

**441—82.13(249A) Records.**

**82.13(1) Content.** The facility shall as a minimum maintain the following records:

- a. All records required by the department of public health and the department of inspections and appeals.
- b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act.
- c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.
- d. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.
- e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.
- f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.
- g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.
  - (1) Census information shall be provided for residents in skilled, intermediate, and residential care.
  - (2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.
  - (3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.
- h. Resident accounts.
- i. Inservice education program records.
- j. Inspection reports pertaining to conformity with federal, state, and local laws.
- k. Residents' personal records.
- l. Residents' medical records.
- m. Disaster preparedness reports.

**82.13(2) Retention.** Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

**82.13(3) Change of owner.** All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

**441—82.14(249A) Payment procedures.**

**82.14(1) Method of payment.** Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—82.5(249A).

**82.14(2) Payment responsibility.** Rescinded IAB 7/11/12, effective 7/1/12.

**82.14(3)** Rescinded IAB 8/9/89, effective 10/1/89.

**82.14(4) Periods authorized for payment.**

- a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.
- b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.
- c. Payment will be approved for the day of admission but not the day of discharge or death.
- d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

*e.* Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

*f.* Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

**82.14(5) *Supplementation.*** Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person.

EXCEPTION: The resident, the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over 10 days on a hospital stay. When the resident is not discharged from the facility, the payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

**82.14(6) *Payment for out-of-state care.*** Rescinded IAB 9/5/90, effective 11/1/90.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0582C, IAB 2/6/13, effective 4/1/13]

#### **441—82.15(249A) Billing procedures.**

**82.15(1) *Claims.*** Claims for service for clients not enrolled with a managed care organization must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through IME's electronic clearinghouse.

*a.* A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

*b.* Adjustments to claims may be made electronically as provided for by the Iowa Medicaid enterprise.

**82.15(2) Reserved.**

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—82.16(249A) Closing of facility.** When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the Iowa Medicaid enterprise for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—82.17(249A) Audits.**

**82.17(1) *Audits of financial and statistical report.*** Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—82.5(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

*a.* When a proper per diem rate cannot be determined, through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

*b.* When a facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

**82.17(2) Auditing of proper billing and handling of patient funds.**

*a.* The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

*b.* The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.9(3).

*c.* The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

*d.* The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

*e.* When the facility fails to comply with paragraph "d" the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

*f.* When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—82.18(249A) Out-of-state facilities.** Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

**82.18(1)** Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

**82.18(2)** Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

**82.18(3)** Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.  
[ARC 0582C, IAB 2/6/13, effective 4/1/13]

**441—82.19(249A) State-funded personal needs supplement.** A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has

appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code section 249A.30A.

[ARC 0582C, IAB 2/6/13, effective 4/1/13]

- [Filed emergency 1/16/76—published 2/9/76, effective 1/16/76]
- [Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
- [Filed 4/13/77, Notice 11/3/76—published 5/4/77, effective 6/8/77]
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CHAPTER 83  
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

**441—83.1(249A) Definitions.**

*“Attorney in fact under a durable power of attorney for health care”* means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Blind individual”* means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

*“Client participation”* means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

*“Deeming”* means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

*“Disabled person”* means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

*“Financial participation”* means client participation and medical payments from a third party including veterans’ aid and attendance.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent homemaker service”* means homemaker service provided from one to three hours a day for not more than four days per week.

*“Intermittent respite service”* means respite service provided from one to three times a week.

*“Managed care organization”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical assessment*” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“*Medical institution*” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“*Medical intervention*” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“*Medical monitoring*” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Substantial gainful activity*” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*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.

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**441—83.2(249A) Eligibility.** To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.2(1) Eligibility criteria.**

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department.

Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

*b.* The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

*c.* Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

*d.* The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

*e.* To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

*f.* The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) "b" and 75.5(4) "c" shall be applied.

*g.* The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

*h.* To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

**83.2(2) Need for services.**

a. The member shall have a service plan approved by the department which is developed by the service worker or targeted case manager identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker or targeted case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually. The service worker or targeted case manager shall have a face-to-face visit with the member at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker or targeted case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,765	\$950	\$3,365

(1) For members eligible for SSI who remain eligible for health and disability waiver services until the age of 25 because they are receiving health and disability waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

(2) If more than \$505 is paid for home and vehicle modification services, the service worker or targeted case manager shall encumber up to \$505 per month within the monthly dollar cap allowed for the member until the total amount of the modification is reached within a 12-month period.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) "b"(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

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**441—83.3(249A) Application.**

**83.3(1)** *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.3(2)** *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

*a.* The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant 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 person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

*b.* If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

*c.* The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

**83.3(3) Approval of application.**

*a.* Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(5) The application is pending because the assessment, Form 470-4392, or the service plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form 470-4392, or service plan, the application shall be denied.

*b.* Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

*c.* An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

*d.* Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

*e.* A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

**83.3(4)** *Effective date of eligibility.*

*a.* Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

*b.* The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) “*a*” and “*c*” do not apply is the date on which the income eligibility and level of care determinations are completed.

*c.* Eligibility for persons covered under subparagraph 83.2(1) “*c*”(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

*d.* Eligibility continues until the member has been in a medical institution for 30 consecutive days for other than respite care. Members who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.3(5)** *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.4(249A) Financial participation.** Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

**83.4(1)** *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client’s total income.

**83.4(2)** *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

**83.4(3)** *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.  
[ARC 0757C, IAB 5/29/13, effective 8/1/13]

**441—83.5(249A) Redetermination.** A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

**83.5(1)** The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

**83.5(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.6(249A) Allowable services.** Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

**441—83.7(249A) Service plan.** A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.5(1) "b." Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

**83.7(1)** The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

**83.7(2)** The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

**83.7(3)** The service plan shall also list all nonwaiver Medicaid services.

**83.7(4)** The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.8(249A) Adverse service actions.**

**83.8(1)** Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) "b," or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

**83.8(2)** Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) "b."

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the service worker or targeted case manager.

e. Service providers are not available.

**83.8(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”  
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

**441—83.9(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

**441—83.10(249A) County reimbursement.** Rescinded IAB 4/9/97, effective 6/1/97.

**441—83.11(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.12 to 83.20** Reserved.

#### DIVISION II—HCBS ELDERLY WAIVER SERVICES

#### **441—83.21(249A) Definitions.**

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Interdisciplinary team*” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
  - a. A physician order for all skilled services.
  - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
  - c. An individualized care plan that identifies support needs.
  - d. Confirmation that skilled services are provided to the member.
  - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
  - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

*“Specialized respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

*“Third-party payments”* means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

*“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.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.22(249A) Eligibility.** To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.22(1) Eligibility criteria.** All of the following criteria must be met. The person must be:

- a. Sixty-five years of age or older.
- b. A resident of the state of Iowa.
- c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) “b” and 75.5(4) “c” shall be applied.
- d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.
  - (1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care. The IME medical services unit shall be responsible for determination of the initial level of care.
  - (2) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.
  - (3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.
  - (4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.
  - e. Determined to need services as described in subrule 83.22(2).
  - f. Rescinded IAB 10/11/06, effective 10/1/06.
  - g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

**83.22(2) Need for services, service plan, and cost.**

*a. Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

*b. Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer's legal representative, family, service providers, and others directly involved in the consumer's care.

(2) *Role.* The team shall identify:

1. The consumer's need for services based on the consumer's needs and desires.
2. Available and appropriate services to meet the consumer's needs.
3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

*c. Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>
\$2,765	\$1,339

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

*d. Content of service plan.* The service plan shall include the following information based on the consumer's current assessment and service needs:

- (1) Observable or measurable individual goals.
- (2) Interventions and supports needed to meet those goals.
- (3) Incremental action steps, as appropriate.
- (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.
- (5) The desired individual outcomes.
- (6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.
- (7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.
- (8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:
  1. The name of the service provider responsible for providing the service.
  2. The funding source for the service.
  3. The amount of service that the consumer is to receive.
- (9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.
- (10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
2. The emergency backup support and crisis response system identified by the interdisciplinary team.
3. Emergency, backup staff designated by providers for applicable services.

**83.22(3) Providers—standards.** Rescinded IAB 10/11/06, effective 10/1/06.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.23(249A) Application.**

**83.23(1) Application for HCBS elderly waiver.** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.23(2) Application for services.** Rescinded IAB 12/6/95, effective 2/1/96.

**83.23(3) Approval of application.**

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

**83.23(4) Effective date of eligibility.**

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.23(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.24(249A) Client participation.** Persons must contribute their predetermined client participation to the cost of elderly waiver services.

**83.24(1) Computation of client participation.** Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

**83.24(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

**441—83.25(249A) Redetermination.** A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

**83.25(1)** The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

**83.25(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.26(249A) Allowable services.** Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

**441—83.27(249A) Service plan.** The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

**83.27(1)** The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

**83.27(2)** The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

**441—83.28(249A) Adverse service actions.**

**83.28(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.22(2) "b," or are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

**83.28(2) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "a," "b," "c," "d," "g," or "h" apply.
- b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2) "b."
- c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

e. Service providers are not available.

**83.28(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

**441—83.29(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.30(249A) Enhanced services.** When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

**441—83.31(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.32 to 83.40** Reserved.

#### DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

**441—83.41(249A) Definitions.**

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Financial participation*” means client participation and medical payments from a third party including veterans' aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*"Service plan"* means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

*"Skilled nursing facility level of care"* means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

*"Specialized respite"* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

*"Third-party payments"* means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

*"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.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.42(249A) Eligibility.** To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.42(1) Eligibility criteria.** All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

*d.* Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

*e.* Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

*f.* Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

*g.* For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

**83.42(2) *Need for services.***

*a.* The department service worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually.

*b.* The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,840.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.43(249A) *Application.***

**83.43(1) *Application for HCBS AIDS/HIV waiver services.*** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.43(2) *Application for services.*** Rescinded IAB 12/6/95, effective 2/1/96.

**83.43(3) *Approval of application.***

*a.* Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

*b.* Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

*c.* An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

*d.* Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

**83.43(4) *Effective date of eligibility.***

*a.* The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

*b.* The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

*c.* Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The

recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

*d.* The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

**83.43(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.44(249A) Financial participation.** Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

**83.44(1) Maintenance needs of the individual.** The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

**83.44(2) Limitation on payment.** If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

**83.44(3) Maintenance needs of spouse and other dependents.** Rescinded IAB 4/9/97, effective 6/1/97.

**441—83.45(249A) Redetermination.** A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

**83.45(1)** The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

**83.45(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.46(249A) Allowable services.** Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

**441—83.47(249A) Service plan.** A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

**83.47(1)** The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

**83.47(2)** The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

**83.47(3)** Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

**83.47(4)** The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

**441—83.48(249A) Adverse service actions.**

**83.48(1)** Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) “b” or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

**83.48(2)** Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “b.”
- c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

**83.48(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

**441—83.49(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.50(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

**441—83.51 to 83.59** Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

**441—83.60(249A) Definitions.**

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Behavior”* means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

*“Case management services”* means those services established pursuant to Iowa Code chapter 225C.

*“Child”* means a person with an intellectual disability aged 17 or under.

*“Client participation”* means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

*“Counseling”* means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

*“Deemed status”* means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

*“Department”* means the Iowa department of human services.

*“Direct service”* means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

*“Fiscal accountability”* means the development and maintenance of budgets and independent fiscal review.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“Health”* means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

*“Immediate jeopardy”* means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

*“Intellectual disability”* means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

*“Intermediate care facility for persons with an intellectual disability (ICF/ID)”* means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent supported community living service”* means supported community living service provided not more than 52 hours per month.

*“Maintenance needs”* means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

*“Managed care”* means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

*“Managed care organization”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

*“Medical assessment”* means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

*“Medical intervention”* means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

*“Natural supports”* means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

*“Organization”* means the entity being certified.

*“Organizational outcome”* means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

*“Outcome”* means an action or event that follows as a result or consequence of the provision of a service or support.

*“Procedures”* means the steps to be taken to implement a policy.

*“Process”* means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

*“Qualified intellectual disability professional”* means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.

7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.

8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. A professional dietitian who is eligible for registration by the American Dietetics Association.

10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

*"Related condition"* means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

*"Service plan"* means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

*"SIS assessment"* means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

*"Specialized respite"* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

*"Staff"* means a person under the direction of the organization to perform duties and responsibilities of the organization.

*"Third-party payments"* means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

*"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.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.61(249A) Eligibility.** To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

**83.61(1) Eligibility criteria.** All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

*b.* Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

*c.* Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

*d.* Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

*e.* Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

*f.* Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

*g.* For supported employment services:

(1) Be at least age 16.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

*h.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.

*i.* To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

*j.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

*k.* For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;
2. Case history that includes previous placements and service programs;
3. Medical history that includes major illnesses and current medications;
4. Current psychological evaluations and consultations;
5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
6. Any current court orders in effect regarding the child;
7. Any legal history;
8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;
2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)"a"; or
3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.
  - l.* For day habilitation, be 16 years of age or older.
  - m.* For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

**83.61(2) Need for services.**

*a.* Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange an SIS assessment.

*b.* Applicants not receiving services as set forth in paragraph 83.61(2)"a" shall have a department service worker or case manager:

- (1) Arrange an SIS assessment for the initial level of care determination;
- (2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and
- (3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

*c.* Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

*d.* Services shall not exceed the number of maximum units established for each service.

*e.* The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

*f.* The case manager shall coordinate with the department to arrange an SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary to arrange the SIS assessment or other circumstances beyond the worker's control.

*g.* At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent SIS assessment or of the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

*h.* Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

**83.61(3)** *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

*a.* The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

*b.* When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

**83.61(4)** *Securing a payment slot.* The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

*a.* A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant 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 person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

*b.* If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment

shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.
2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.
3. The applicant is living in a homeless shelter and no alternative housing options are available.
4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.
5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.
2. The caregiver will be unable to continue to provide care within the next 60 days.
3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.
4. The applicant is living in temporary housing and plans to move within 31 to 120 days.
5. The applicant is losing permanent housing and plans to move within 31 to 120 days.
6. The caregiver will be unable to be employed if services are not available.
7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.
8. The applicant has behaviors that put the applicant at risk.
9. The applicant has behaviors that put others at risk.
10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) "b"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—83.62(249A) Application.**

**83.62(1)** *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.62(2)** Rescinded IAB 6/5/96, effective 8/1/96.

**83.62(3)** *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

**83.62(4)** *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

**83.62(5)** *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical

institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15]

**441—83.63(249A) Client participation.** Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

**83.63(1) Computation of client participation.** Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

**83.63(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

**441—83.64(249A) Redetermination.** A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

**83.64(1)** The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

**83.64(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.65(249A)** Rescinded IAB 6/5/96, effective 8/1/96.

**441—83.66(249A) Allowable services.** Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

**441—83.67(249A) Service plan.** A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

**83.67(1) Development.** The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

**83.67(2) Retention.** The service plan shall be stored by the case manager for a minimum of three years.

**83.67(3) Interdisciplinary team meeting.** The interdisciplinary team meeting shall be conducted before the current service plan expires.

**83.67(4) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:

- (1) The consumer's living environment at the time of waiver enrollment.
- (2) The number of hours per day of on-site staff supervision needed by the consumer.
- (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
  - (1) Maintenance of personal funds.
  - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.67(5) Documentation.** The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

**83.67(6) Approval of plan.** The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

#### **441—83.68(249A) Adverse service actions.**

**83.68(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

**83.68(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

**83.68(3) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2) paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

- g. The consumer receives services from other Medicaid waiver programs.
  - h. The consumer or legal representative through the interdisciplinary process requests termination from the services.
- [ARC 9650B, IAB 8/10/11, effective 10/1/11]

**441—83.69(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).  
[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

**441—83.70(249A) County reimbursement.** Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

**441—83.71(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

**441—83.72(249A) Rent subsidy program.** Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.  
[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.73 to 83.80** Reserved.

#### DIVISION V—BRAIN INJURY WAIVER SERVICES

**441—83.81(249A) Definitions.**

*“Adaptive”* means age appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

*“Adult”* means a person with a brain injury aged 18 years or over.

*“Appropriate”* means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

*“Assessment”* means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

*“Attorney in fact under a durable power of attorney for health care”* means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Behavior”* means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

*“Brain injury”* means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.

Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.

Malignant neoplasms of brain, cranial nerves.

Secondary malignant neoplasm of brain.

Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.

Benign neoplasm of brain and other parts of the nervous system, brain.

Benign neoplasm of brain and other parts of the nervous system, cranial nerves.

Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.

Encephalitis, myelitis and encephalomyelitis.

Intracranial and intraspinal abscess.

Anoxic brain damage.

Subarachnoid hemorrhage.

Intracerebral hemorrhage.

Other and unspecified intracranial hemorrhage.

Occlusion and stenosis of precerebral arteries.

Occlusion of cerebral arteries.

Transient cerebral ischemia.

Acute, but ill-defined, cerebrovascular disease.

Other and ill-defined cerebrovascular diseases.

Fracture of vault of skull.

Fracture of base of skull.

Other and unqualified skull fractures.

Multiple fractures involving skull or face with other bones.

Concussion.

Cerebral laceration and contusion.

Subarachnoid, subdural, and extradural hemorrhage following injury.

Other and unspecified intracranial hemorrhage following injury.

Intracranial injury of other and unspecified nature.

Poisoning by drugs, medicinal and biological substances.

Toxic effects of substances.

Effects of external causes.

Drowning and nonfatal submersion.

Asphyxiation and strangulation.

Child maltreatment syndrome.

Adult maltreatment syndrome.

*“Case management services”* means those services established pursuant to Iowa Code chapter 225C.

*“Child”* means a person with a brain injury aged 17 years or under.

*“Client participation”* means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

*“Deemed status”* means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

*“Department”* means the Iowa department of human services.

*“Direct service”* means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

*“Fiscal accountability”* means the development and maintenance of budgets and independent fiscal review.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“Health”* means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

*“Immediate jeopardy”* means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent supported community living service”* means supported community living service provided from one to three hours a day for not more than four days a week.

*“Managed care organization”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

*“Medical assessment”* means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

*“Medical intervention”* means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

*“Natural supports”* means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“Organization”* means the entity being certified.

*“Organizational outcome”* means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

*“Outcome”* means an action or event that follows as a result or consequence of the provision of a service or support.

*“Procedures”* means the steps to be taken to implement a policy.

*“Process”* means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

*“Qualified brain injury professional”* means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two

years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

*"Service coordination"* means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

*"Service plan"* means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

*"Skilled nursing facility level of care"* means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
  - a. A physician order for all skilled services.
  - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
  - c. An individualized care plan that identifies support needs.
  - d. Confirmation that skilled services are provided to the member.
  - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
  - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

*"Specialized respite"* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

*"Staff"* means a person under the direction of the organization to perform duties and responsibilities of the organization.

*"Third-party payments"* means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

*"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.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.82(249A) Eligibility.** To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

**83.82(1) Eligibility criteria.** All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.

- j.* To be eligible for interim medical monitoring and treatment services the consumer must be:
- (1) Under the age of 21;
  - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
  - (3) Residing in the consumer's family home or foster family home; and
  - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- k.* Receive services in a community, not an institutional, setting.
- l.* Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m.* For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

**83.82(2) Need for services.**

*a.* The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

*b.* Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) "b"(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services, excluding the cost of case management and home and vehicle modifications, shall not exceed \$2,954 per month.

**83.82(3)** *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

**83.82(4)** *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

#### **441—83.83(249A) Application.**

**83.83(1)** *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.83(2)** *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

**83.83(3) *Effective date of eligibility.***

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.83(4) *Attribution of resources.*** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.84(249A) Client participation.** Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

**83.84(1) *Computation of client participation.*** Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

**83.84(2) *Limitation on payment.*** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

**441—83.85(249A) Redetermination.** A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in

accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

**441—83.86(249A) Allowable services.** Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

**441—83.87(249A) Service plan.** A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

**83.87(1) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
  - (1) The consumer's living environment at the time of waiver enrollment.
  - (2) The number of hours per day of on-site staff supervision needed by the consumer.
  - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
  - (1) Maintenance of personal funds.
  - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.87(2) Use of nonwaiver services.** Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

**83.87(3) Annual assessment.** The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

- a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.
- b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

**83.87(4) Service file.** The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

*a. to d.* Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.88(249A) Adverse service actions.**

**83.88(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a.* The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b.* Service needs exceed the service unit or reimbursement maximums.
- c.* Service needs are not met by the services provided.
- d.* Needed services are not available or received from qualifying providers.
- e.* The brain injury waiver service is not identified in the consumer's service plan.
- f.* There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g.* The consumer receives services from other Medicaid waiver providers.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

**83.88(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

**83.88(3) Termination.** A particular service may be terminated when the department determines that:

- a.* The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b.* Needed services are not available or received from qualifying providers.
- c.* The brain injury waiver service is not identified in the consumer's annual service plan.
- d.* Service needs are not met by the services provided.
- e.* Services needed exceed the service unit or reimbursement maximums.
- f.* Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g.* The consumer receives services from other Medicaid providers.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

**441—83.89(249A) Appeal rights.** Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

**441—83.90(249A) County reimbursement.** Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

**441—83.91(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.92 to 83.100** Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

**441—83.101(249A) Definitions.**

“*Adaptive*” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a physical disability aged 18 years to 64 years.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Client participation*” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a guardian appointed in probate court for an adult.

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Physical disability*” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.

- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.
- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.102(249A) Eligibility.** To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

**83.102(1) Eligibility criteria.** All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(3) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

**83.102(2) Need for services.**

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The service worker shall identify the need for service based on the needs of the applicant, as documented in Form 470-5044, Service Worker Comprehensive Assessment, as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$692 per month.

**83.102(3) Slots.** The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

**83.102(4) County payment slots for persons requiring the ICF/MR level of care.** Rescinded IAB 10/6/99, effective 10/1/99.

**83.102(5) Securing a slot.**

*a.* The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

*b.* If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

**83.102(6) Securing a county payment slot.** Rescinded IAB 10/6/99, effective 10/1/99.

**83.102(7) HCBS physical disability waiver waiting list.** When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

#### **441—83.103(249A) Application.**

**83.103(1) Application for financial eligibility.** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

**83.103(2) Approval of application for eligibility.**

*a.* Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker or case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

**83.103(3) *Effective date of eligibility.***

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.103(4) *Attribution of resources.*** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.104(249A) Client participation.** Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

**83.104(1) *Computation of client participation.*** Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

**83.104(2) *Limitation on payment.*** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

**441—83.105(249A) *Redetermination.*** A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

**441—83.106(249A) *Allowable services.*** The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

**441—83.107(249A) *Individual service plan.*** An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

**83.107(1) *Information in plan.*** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.107(2) *Annual assessment.*** The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

**83.107(3) *Case file.*** Rescinded IAB 8/7/02, effective 10/1/02.  
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.108(249A) Adverse service actions.**

**83.108(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

**83.108(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

**83.108(3) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

**441—83.109(249A) Appeal rights.** Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

**83.109(1) Appeal to county.** Rescinded IAB 2/7/01, effective 2/1/01.

**83.109(2) Reconsideration request to IME medical services unit.** Rescinded IAB 9/5/12, effective 11/1/12.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.110(249A) County reimbursement.** Rescinded IAB 10/6/99, effective 10/1/99.

**441—83.111(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.112 to 83.120** Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

**441—83.121(249A) Definitions.**

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a written, consumer-centered, outcome-based plan of services developed by the consumer’s interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.122(249A) Eligibility.** To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

**83.122(1) Age.** The consumer must be under 18 years of age.

**83.122(2) Diagnosis.** The consumer must be diagnosed with a serious emotional disturbance.

*a. Initial certification.* For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

*b. Ongoing certification.* A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

**83.122(3) Level of care.** The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant’s level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

**83.122(4) Financial eligibility.** The consumer must be eligible for Medicaid as follows:

*a.* Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

*b.* Be eligible under the special income level (300 percent) coverage group; or

*c.* Become eligible through application of the institutional deeming rules; or

*d.* Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

**83.122(5) Choice of program.** The applicant must choose HCBS children’s mental health waiver services over institutional care, as indicated by the signature of the applicant’s parent or legal guardian on Form 470-4694, Case Management Comprehensive Assessment.

**83.122(6) Need for service.** The consumer must have service needs that can be met under the children’s mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

*a.* The consumer must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

*b.* The total cost of children’s mental health waiver services needed to meet the member’s needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$1,967 per month.

*c.* At a minimum, each consumer must receive one billable unit of a children’s mental health waiver service per calendar quarter.

*d.* A consumer may not receive children’s mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

*e.* A consumer may be enrolled in only one HCBS waiver program at a time.

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**441—83.123(249A) Application.** The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children’s mental health waiver services.

**83.123(1) Program limit.** The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

*a.* The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member;

(2) Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or

(3) A written request signed and dated by a Medicaid member's parent or legal guardian.

*b.* When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) 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 consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

*c.* If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

*d.* Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

**83.123(2) Approval of waiver eligibility.**

*a. Time limit.* Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

*b. Notice of decisions.* The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

**83.123(3) *Effective date of eligibility.*** The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

- a. All eligibility requirements are met; and
- b. Eligibility and level of care determinations have been made.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.124(249A) Financial participation.** A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

**441—83.125(249A) Redetermination.** The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

**83.125(1) *Eligibility review.***

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed department-approved assessment and supporting documentation as needed.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

**83.125(2) *Continuation of eligibility.*** A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.

(1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

**83.125(3) *Payment slot.*** When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.126(249A) Allowable services.** Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;

3. In-home family therapy; and
4. Respite care.

**441—83.127(249A) Service plan.** The consumer's case manager shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

**83.127(1)** The service plan shall be developed through an interdisciplinary team process.

**83.127(2)** The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

**83.127(3)** The service plan shall be based on information in Form 470-4694, Case Management Comprehensive Assessment.

**83.127(4)** The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

**83.127(5)** The service plan shall identify and justify any restriction of the consumer's rights.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.128(249A) Adverse service actions.**

**83.128(1) Denial.** An application for children's mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) "c" or are not met by the services provided.

**83.128(2) Termination.** A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) "c."
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager.
- e. Service providers are not available.

**83.128(3) Reduction.** Reduction of services shall apply as specified in 441—paragraphs 130.5(3) "a" and "b."

**441—83.129(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

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These rules are 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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CHAPTER 85  
SERVICES IN PSYCHIATRIC INSTITUTIONS

PREAMBLE

Inpatient psychiatric services are provided in three types of psychiatric facilities in addition to general hospitals with psychiatric units: acute care psychiatric hospitals, psychiatric medical institutions for children, and nursing facilities for the mentally ill. Except for services in the state mental health institutes, Medicaid covers only persons under the age of 21 and persons aged 65 and older in acute care psychiatric hospitals. Medicaid covers only persons under the age of 21 in psychiatric medical institutions for children, and only persons aged 65 and older in nursing facilities for the mentally ill. These rules establish conditions of participation for providers, record-keeping requirements, reimbursement methodologies, and client eligibility requirements.

DIVISION I  
PSYCHIATRIC HOSPITALS

**441—85.1(249A) Acute care in psychiatric hospitals.** These rules do not apply to general hospitals with psychiatric units.

**85.1(1)** *Psychiatric hospitals serving persons aged 21 and older.* A psychiatric hospital serving persons aged 21 and older shall meet the federal criteria for an institution for mental disease and shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B). An out-of-state facility shall be licensed as a psychiatric hospital, shall meet the federal criteria for an institution for mental disease, and shall be certified to participate in the Medicare program. An institution is an institution for mental disease only if its overall character is that of a facility established and maintained primarily for the care and treatment of persons with mental diseases. The following guidelines are used by the department in evaluating the overall character of a facility. These guidelines are all useful in identifying institutions for mental disease; however, no single guideline is necessarily determinative in any given case.

*a.* The facility:

- (1) Is licensed as a psychiatric facility for the care and treatment of persons with mental diseases.
- (2) Advertises or holds itself out as a facility for the care and treatment of persons with mental diseases.
- (3) Is accredited as a psychiatric facility by the Joint Commission on the Accreditation of Health Care Organizations or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals.

(4) Specializes in providing psychiatric or psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric or psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

(5) Is under the jurisdiction of the division of behavioral, developmental, and protective services for families, adults, and children of the department.

*b.* More than 50 percent of all the patients in the facility have mental diseases which require inpatient treatment according to the patient's medical records.

*c.* A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders.

*d.* Independent review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.

*e.* The average patient age is significantly lower than that of a typical nursing home.

*f.* Part or all of the facility consists of locked wards.

**85.1(2)** *Psychiatric hospitals serving persons under the age of 21.* A psychiatric hospital serving persons under the age of 21 shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B) or shall be licensed in another state as a hospital, shall be accredited by the Joint

Commission on the Accreditation of Health Care Organizations, the Commission of Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals, and shall meet federal service requirements.

**441—85.2(249A) Out-of-state placement.** Placement in an out-of-state psychiatric hospital for acute care requires prior approval by the bureau of managed care and clinical services and shall be approved only if special services are not available in Iowa facilities as determined by the division of behavioral, developmental, and protective services for families, adults, and children.

**441—85.3(249A) Eligibility of persons under the age of 21.**

**85.3(1) Age.** To be eligible for payment for the cost of care provided by a psychiatric hospital, the person shall be under 21 years of age. When treatment in the hospital is provided immediately preceding the person's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

**85.3(2) Period of eligibility.** The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status the eligible person is entitled to the full scope of Medicaid benefits.

**85.3(3) Certification of need for care.** For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

*a.* For persons eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

*b.* When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

*c.* For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

**85.3(4) Financial eligibility for persons under the age of 21.** To be eligible for payments for the cost of care provided by a psychiatric facility, persons under the age of 21 must be eligible under one of the coverage groups listed in rule 441—75.1(249A).

**441—85.4(249A) Eligibility of persons aged 65 and over.** To be eligible for payment for the cost of care provided by an institution for mental disease, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A).

**441—85.5(249A) Client participation.**

**85.5(1) Before July 2005.** For months before July 2005, the resident shall be liable to pay client participation toward the cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

**85.5(2)** *July 2005 and after.* Effective with the month of July 2005, the resident shall not be liable to pay client participation toward the cost of care, and no client participation amount shall be deducted from the state payment to the hospital.

**441—85.6(249A) Responsibilities of hospitals.**

**85.6(1)** *Medical record requirements.* The medical records maintained by the psychiatric hospital shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the hospital.

*a.* Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

*b.* Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within 60 hours of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

*c.* Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

*d.* Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

*e.* Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

*f.* The facility shall obtain a professional review organization (PRO) determination that the person requires acute psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care general hospital, or enters the facility after 30 consecutive days of visitation.

**85.6(2) Fiscal records.**

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized in a general hospital, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

**85.6(3) Additional requirements.** Additional requirements are mandated for persons under the age of 21.

a. *Active treatment.* Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. *Individual plan of care.* An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph "c" below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. *Interdisciplinary team.* The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

**441—85.7(249A) Psychiatric hospital reimbursement.**

**85.7(1) Reimbursement formula.** Acute care in psychiatric hospitals shall be reimbursed on a per diem rate based on Medicare principles.

*a.* The reimbursement principles follow and comply with the retrospective Principles of Medicare reimbursement found in Title 18 of the Social Security Act and amendments to that Act, Medicare regulations found in the Health Insurance Regulation Manual (HIRM-1), and General Instructions-Health Insurance Manual sections 10, 11, 12 and 15 when applicable.

*b.* Allowable costs are those defined as allowable in 42 CFR, Subpart A, Sections 413.5 and 413.9, as amended to December 2, 1996, and 42 CFR 447.250 as amended to September 23, 1992. Only those costs are considered in calculating the Medicaid inpatient reimbursement.

*c.* Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost and to adhere to all Medicare cost principles in the calculation of the facility rates.

*d.* Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate equal to the statewide average Medicaid skilled nursing facility rate or the average state nursing facility rate. Periodic PRO determinations of the need for continuing care are also required.

*e.* Each participating Medicaid provider shall file a CMS 2552 Medicare Cost Report or a substitute accepted by the Centers for Medicare and Medicaid Services. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the Iowa Medicaid enterprise provider audits and rate-setting unit for Iowa within 150 days after the close of the hospital's fiscal year.

*f.* Compensation for a disproportionate share of indigent patients is determined as described in 441—subrule 79.1(5).

*g.* Medicaid reimbursement shall be reduced by any payments from a third party toward the cost of a patient's care.

**85.7(2) *Medical necessity.*** The medical necessity of admission and continued stay will be determined by the PRO. Payment shall not be made for admissions which are determined not to be medically necessary nor will payment be approved for stays beyond the time at which inpatient specialized hospital care at the acute level has been determined not to be medically necessary.

**85.7(3) *Reserve bed day payment.*** No reserve bed day payments are made to acute care psychiatric hospitals.

**85.7(4) *Outpatient services.*** No coverage is available for outpatient psychiatric hospital services. These rules are intended to implement Iowa Code section 249A.4.

#### **441—85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64.**

**85.8(1) *Facility.*** Acute care in a psychiatric hospital is covered for persons aged 21 through 64 only at the state mental health institutes at Cherokee, Clarinda, Independence, and Mount Pleasant.

**85.8(2) *Basis of eligibility.*** To be eligible for payment for the cost of care provided by one of the covered facilities, a person aged 21 through 64 must be either:

*a.* Eligible for one of the coverage groups listed in 441—75.1(249A); or

*b.* Eligible under the IowaCare program pursuant to 441—Chapter 92.

**85.8(3) *Period of eligibility.*** A person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of discharge.

**85.8(4) *Extent of eligibility.***

*a.* While on inpatient status, a person eligible under a coverage group listed in 441—75.1(249A) is entitled to the full scope of Medicaid benefits.

*b.* While on inpatient status, a person eligible under the IowaCare program is entitled to the services listed at 441—92.8(249A,81GA,ch167).

**441—85.9 to 85.20** Reserved.

DIVISION II  
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

**441—85.21(249A) Conditions for participation.** Psychiatric medical institutions for children shall be issued a license by the department of inspections and appeals under Iowa Code chapter 135H and shall hold either a license from the department of human services under Iowa Code section 237.3, subsection 2, paragraph “a,” subparagraph (3) or, for facilities which provide substance abuse treatment, a license from the department of public health under Iowa Code section 125.13.

This rule is intended to implement Iowa Code sections 135H.4 and 249A.4.

**441—85.22(249A) Eligibility of persons under the age of 21.**

**85.22(1) Age.** To be eligible for payment for the cost of care provided by a psychiatric medical institution for children, the person shall be under 21 years of age. When treatment in the facility is provided immediately preceding the individual’s twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

**85.22(2) Period of eligibility.** The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status, the eligible individual is entitled to the full scope of Medicaid benefits.

**85.22(3) Certification for need for care.** For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

*a.* For persons determined eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person’s situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient’s admission.

*b.* When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

*c.* For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

**85.22(4) Financial eligibility for persons under the age of 21.** To be eligible for payments for the cost of care provided by psychiatric medical institutions, persons under the age of 21 shall be eligible under one of the coverage groups listed in rule 441—75.1(249A), except medically needy.

**441—85.23(249A) Client participation.** The resident’s client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

**441—85.24(249A) Responsibilities of facilities.**

**85.24(1) Medical record requirements.** The medical records maintained by psychiatric medical institutions for children shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the facility.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is admitted.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within seven days of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's stay at the facility and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires psychiatric medical institution level of care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

**85.24(2) Fiscal records.**

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

**85.24(3) Additional requirements.** Additional requirements are mandated for persons under the age of 21.

*a. Active treatment.* Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

*b. Individual plan of care.* An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph "c" below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

*c. Interdisciplinary team.* The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility. Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are involved in the direct provision of treatment services, involved in the organization of the plan of care, or involved in consulting with or supervising those professionals involved in the direct provision of care.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

#### **441—85.25(249A) Reimbursement to psychiatric medical institutions for children.**

**85.25(1)** *Computation of inpatient rate for non-state-owned facilities prior to July 1, 2014, and for state-owned facilities.* For services rendered by non-state-owned facilities on or before June 30, 2014, or by state-owned facilities, facilities are paid at a per diem rate based on the facility's actual and allowable cost for the service not to exceed the upper limit as provided in 441—subrule 79.1(2).

*a.* Rates for new facilities are based on historical costs submitted on Form 470-0664, Financial and Statistical Report for Purchase of Service Contracts, if the institution is established and has the historical data. If the institution is newly established, the rate shall be based on a proposed budget submitted on

Form 470-0664. A Form 470-0664 with actual cost data shall be submitted after at least six months of participation in the program for a new rate adjustment.

*b.* After the initial cost report period, the institution shall submit Form 470-0664 annually within three months of the close of the facility's fiscal year. Failure to submit the report within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

*c.* For services rendered on or after August 1, 2011, rates paid shall be adjusted to 100 percent of the facility's actual and allowable average costs per patient day, based on the cost information submitted pursuant to paragraphs 85.25(1) "a" and "b," subject to the upper limit provided in 441—subrule 79.1(2) for non-state-owned facilities. Before rate adjustment, providers shall be paid a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate.

**85.25(2)** *Inpatient reimbursement for non-state-owned facilities effective January 1, 2016.* Services rendered by non-state-owned facilities on or after January 1, 2016, are paid on a fee-for-service basis.

**85.25(3)** *Reserve bed payments.*

*a.* Reserve bed day payment for days a resident of a psychiatric medical institution for children is absent from the facility for hospitalization in an acute care general hospital is paid in accordance with the following policies:

(1) The intent of the department and the facility shall be for the resident to return to the facility after the hospitalization.

(2) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the hospitalization.

(3) Payment for reserve bed days shall be canceled and payment returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment will not be authorized for over ten days per calendar month and will not be authorized for over ten days for any continuous hospital stay.

*b.* Reserve bed days for visitation shall be made for days a resident is absent from a psychiatric medical institution for children at the time of a nightly census for the purpose of visitation when the absence is in accordance with the following policies:

(1) The visits are consistent with the child's case permanency plan and the facility's individual case plan.

(2) The intent of the department and the facility shall be for the child to return to the facility after the visitation.

(3) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the visit.

(4) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment for reserve bed days shall be canceled effective the day after a decision not to return the child is made by the court or, in a voluntary placement, by the parent.

(6) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

*c.* Reserve bed payment shall be made for days a resident is absent from a psychiatric medical institution for children at the time of the nightly census for reasons such as detention, shelter care, or running away when the absence is in accordance with the following policies:

(1) The intent of the department and the psychiatric medical institution for children shall be for the child to return to the facility after the absence.

(2) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(3) Payment for reserve bed days shall be canceled effective the day after a decision is made not to return the child by the court or, in a voluntary placement, by the parent.

(4) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

(5) Reserve bed day payment is not available until the child has been physically admitted to the psychiatric medical institution.

(6) The psychiatric medical institution shall notify the department social worker within 24 hours after the child is out of the facility for running away or other unplanned reasons.

**85.25(4) Day treatment rates.** Outpatient day treatment services are paid on a fixed fee basis. [ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9710B, IAB 9/7/11, effective 8/17/11; ARC 0028C, IAB 3/7/12, effective 4/11/12; ARC 2026C, IAB 6/10/15, effective 8/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—85.26(249A) Outpatient day treatment for persons aged 20 or under.** Payment to a psychiatric medical institution for children will be approved for day treatment services for persons aged 20 or under if the psychiatric medical institution for children is certified by the department of inspections and appeals for day treatment services and the services are provided on the licensed premises of the psychiatric medical institution for children.

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. All conditions for the day treatment program for persons aged 20 or under as outlined in 441—subrule 78.16(7) for community mental health centers shall apply to psychiatric medical institutions for children.

These rules are intended to implement Iowa Code section 249A.4.

**441—85.27 to 85.40** Reserved.

DIVISION III  
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

**441—85.41(249A) Conditions of participation.** A nursing facility for persons with mental illness shall be licensed pursuant to department of inspections and appeals rules 481—Chapter 65, or, if the facility is a distinct part of a hospital, pursuant to department of inspections and appeals rule 481—51.33(135B). A distinct part of a general hospital may be considered a psychiatric institution. In addition, the facility shall be certified to participate in the Iowa Medicaid program as a nursing facility pursuant to 441—Chapter 81 and shall be 16 beds or more. The facility shall also meet the criteria set forth in subrule 85.1(1).

**441—85.42(249A) Out-of-state placement.** Placement in out-of-state nursing facilities for persons with mental illness is not payable.

**441—85.43(249A) Eligibility of persons aged 65 and over.** To be eligible for payment for the cost of care provided by nursing facilities for persons with mental illness, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A), except for medically needy.

**441—85.44(249A) Client participation.** The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

**441—85.45(249A) Responsibilities of nursing facility.**

**85.45(1) Medical record requirements.** The facility shall obtain a PRO determination that the person requires psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

**85.45(2) Fiscal records.**

*a.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

*b.* The facility shall bill after each calendar month for the previous month's services.

**441—85.46(249A) Policies governing reimbursement.** Cost reporting, reserve bed day payment, and reimbursement shall be the same for nursing facilities for persons with mental illness as for nursing facilities as set forth in 441—Chapter 81.

**441—85.47(249A) State-funded personal needs supplement.** A Medicaid member living in an intermediate care facility for persons with mental illness who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 88  
SPECIALIZED MANAGED CARE PROGRAMS

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter provides for specialized programs of managed care, within the Iowa medical assistance program but outside of managed care pursuant to 441—Chapter 73. Managed care providers under these programs are not required to comply with 441—Chapter 73.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

DIVISION I  
PREPAID HEALTH PLANS

**441—88.1(249A) Definitions.**

“*Capitation rate*” shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

“*Contract*” shall mean a contract between the department and a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

“*Department*” shall mean the Iowa department of human services.

“*Emergency service*” shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient’s health.

“*Enrollment area*” shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

“*Grievance*” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the PHP staff member receiving the complaint or any complaint received in writing.

“*Managed health care*” shall mean any one of the alternative deliveries of regular, fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), or prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“*Managed health care review committee*” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“*Managed services*” shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

“*Nonmanaged services*” shall mean medical services covered under regular Medicaid, but which are not covered in the PHP’s contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

“*Participating providers*” shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

“*Prepaid health plan (PHP)*” shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

“*Recipient*” shall mean any person determined by the department to be eligible for Medicaid and for PHP enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for PHP enrollment.

“*Routine care*” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“*Urgent, nonemergency need*” shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.2(249A) Participation.**

**88.2(1) *Contracts with PHPs.*** The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with PHPs.

a. The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

**88.2(2) *Method of selection of PHP.*** In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

**88.2(3) *Termination of contract.*** Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based upon, but not limited to, the following:

a. The PHP’s delivery system does not ensure enrolled recipients adequate access to medical services.

b. The PHP’s delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of solvency on the part of the PHP.

d. There is not substantial compliance with all provisions of the contract.

*e.* The PHP has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

**88.2(4) Recipients eligible to enroll.** Any Medicaid-eligible recipient is eligible to enroll in a contracting PHP except for the following:

- a.* Recipients who are medically needy as defined at 441—subrule 75.1(35).
- b.* Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
- c.* Recipients who are supplemental security income-related case members.
- d.* Rescinded IAB 10/3/01, effective 12/1/01.
- e.* Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
- f.* Recipients who are foster care and subsidized adoption-related case members.
- g.* Recipients who are Medicare beneficiaries.
- h.* Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
- i.* Recipients who are Native American Indians or Alaskan natives.
- j.* Recipients who are receiving services from a Title V provider.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.3(249A) Enrollment.**

**88.3(1) Enrollment area.** Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.1(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

**88.3(2) Voluntary enrollment.** When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.3(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.3(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

**88.3(3) Mandatory enrollment.** In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

**88.3(4) Effective date.** The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the form designated by the managed health care contractor.

**88.3(5) Identification card.** The PHP may issue an appropriate identification card to the enrolled recipient or request the department to do so on its behalf. The identification card shall be issued so that the recipient receives it prior to the effective date of enrollment.

**88.3(6) Assignment methodology.** When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

*a. Notification.* Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

*b. Limitations.* Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

*c. Household member enrollment.* Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

*d. Assigned recipients who desire another choice.* Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.3(4) and 88.4(2) dealing with effective date.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.4(249A) Disenrollment.**

**88.4(1) Disenrollment request.** An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.3(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

**88.4(2) Effective date.** Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the PHP and the PHP will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

**88.4(3) Disenrollment process.** If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three working days.

*a. Request for disenrollment by the recipient.* In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care

programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

*b. Request for disenrollment by the PHP.* With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

- (1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.
- (2) There is evidence of unauthorized use of the PHP identification card.
- (3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

**88.4(4) *Disenrollments by the department.*** Disenrollments will occur when:

- a.* The contract between the department and the PHP is terminated.
- b.* The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.
- c.* The recipient permanently moves outside the PHP's enrollment area.
- d.* The recipient transfers to an eligibility group excluded from PHP enrollment. See definition of recipient in rule 441—88.1(249A).
- e.* The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

**88.4(5) *No disenrollment for health reasons.*** No recipient shall be disenrolled from a PHP because of an adverse change in health status.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.5(249A) Covered services.**

**88.5(1) *Amount, duration, and scope of services.*** Except as provided for in the contract, PHPs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

**88.5(2) *Mandatory services.***

*a.* Although the contract may specify additional services covered (with the exception of those defined in 88.5(3)), the PHP shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Laboratory and X-ray services.
- (7) Early periodic screening, diagnosis and treatment for persons under age 21.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.

*b.* PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

*c.* According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

**88.5(3) *Excluded services.*** Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule

441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

**88.5(4) *Restrictions and limitations.*** If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

**88.5(5) *Recipient use of PHP services.*** An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.5(2) “c,” and rule 441—88.6(249A).

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.6(249A) Emergency services.**

**88.6(1) *Availability of services.*** The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP’s own providers or through arrangements with other providers. In addition, the PHP must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

**88.6(2) *PHP payment liability.*** PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP’s enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP’s enrollment area, the PHP shall pay the facility or person who provided the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

**88.6(3) *Notification and claim filing time span.*** The PHP may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.7(249A) Access to service.**

**88.7(1) *Choice of provider.*** Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the PHP providers participating in the Medicaid contract.

**88.7(2) *Medical service delivery sites.*** Medical service delivery sites shall have the following specific characteristics:

- a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.
- b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more acute care hospitals.
- c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.
- d. Meet the applicable standards for participating in the Medicaid program.
- e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

**88.7(3) Adequate appointment system.** The PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

- a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP medical service delivery site.
- b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.
- c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.
- d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

**88.7(4) Adequate after hours call-in coverage.** The PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

- a. Twenty-four-hour-a-day telephone coverage shall exist.
- b. If a physician does not respond to the initial telephone call, there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided within 30 minutes.
- c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

**88.7(5) Adequate referral system.** The PHP must effect the following arrangements which provide for an adequate referral system:

- a. A network of referral sources for all services which are covered in the contract, but not directly provided by the PHP.
- b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.
- c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.8(249A) Grievance procedures.**

**88.8(1) Written procedure.** The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, or recommendations, either individually or as a class and which:

- a. Is approved by the department prior to use.
- b. Acknowledges receipt of a grievance to the grievant.
- c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.
- d. Ensures the participation of persons with authority to require corrective action.
- e. Includes at least one level of appeal.
- f. Ensures the confidentiality of the grievant.

**88.8(2) Written record.** All grievances, including all informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be retained and made available at the time of audit and must include progress notes and method of resolution.

**88.8(3) Information concerning grievance procedures.** The PHP's written grievance procedure must be provided to each newly enrolled recipient not later than the effective date of coverage.

**88.8(4) Appeals to the department.** A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

**88.8(5) Periodic report to the department.** The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.9(249A) Records and reports.**

**88.9(1) *Medical records system.*** The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

- a. Identifies each medical record by the departmentally assigned state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).
- f. Maintains inactive medical records in a specific place.
- g. Permits effective professional review in medical audit processes.
- h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i. Meets state and federal reporting requirements applicable to PHPs.

**88.9(2) *Content of individual medical record.*** The PHP must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

**88.9(3) *Confidentiality of records.*** PHPs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or the responsible party acting on behalf of the enrolled recipient.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.
- c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).
- d. Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.
- e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or facility requesting the information.
- f. Medical records maintained by subcontracting providers must meet the requirements of this rule.

**88.9(4) *Reports to the department.*** Each PHP shall submit reports to the department as follows:

- a. Annual audited financial statements no later than 120 days after the close of the PHP’s fiscal year.
- b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

**88.9(5) *Audits.*** The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means, the quality, appropriateness, and timeliness of services performed by the PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.10(249A) Marketing.**

**88.10(1) *Marketing procedures.*** All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

**88.10(2) *Marketing representatives.*** Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The PHP's marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

**88.10(3) *Marketing presentations.*** The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

**88.10(4) *Marketing materials.*** Written material must include a marketing brochure or a member handbook which fully explains the services available, how and when to obtain them, and special factors applicable to enrolled recipients as specified in the contract.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.11(249A) Patient education.**

**88.11(1) *Use of services.*** The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

**88.11(2) *Patient rights and responsibilities.*** The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.12(249A) Payment to the PHP.**

**88.12(1) *Capitation rate.*** In consideration for all services rendered by a PHP under a contract with the department, the PHP will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

**88.12(2) *Determination of rate.*** The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.5(3). PHPs electing to share risk with the department will have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

**88.12(3) *Amounts not included in rate.*** The capitation rate does not include any amounts for the recoupment of losses suffered by the PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

**88.12(4) *Third-party liability.*** If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment.

The PHP shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.13(249A) Quality assurance.** The PHP shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.14 to 88.20** Reserved.

DIVISION II  
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

**441—88.21(249A) Scope and definitions.**

**88.21(1) Purpose.** A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

- a. Enhance the quality of life and autonomy of frail older adults.
- b. Maximize the dignity of and respect for frail older adults.
- c. Enable frail older adults to live in the community as long as medically and socially feasible.
- d. Preserve and support frail older adults' family units.

**88.21(2) Scope.** PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.

b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

**88.21(3) Authorization.** A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

**88.21(4) Definitions.** For purposes of this division:

“*Alternate PACE service site*” means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

“*Capitation rate*” means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

“*CMS*” means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

“*Contract year*” means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

“*Department*” means the Iowa department of human services.

“*Enrollee*” means a person who is enrolled in a PACE program.

“*Federal PACE regulations*” means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

“*Interdisciplinary team*” means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

“*Medicaid enrollee*” means a Medicaid member who is enrolled in a PACE program.

“*Medicare beneficiary*” means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

“*Medicare enrollee*” means a Medicare beneficiary who is enrolled in a PACE program.

“*PACE*” means programs of all-inclusive care for the elderly.

“*PACE center*” means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. “Primary care” shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

“*PACE enrollment agreement*” means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

“*PACE organization*” means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

“*PACE program*” means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

“*PACE program agreement*” means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

“*Service area*” means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

“*Services*” means both items and services provided to an enrollee by the PACE organization.

“*Trial period*” means the first three contract years in which a PACE organization operates under a PACE program agreement.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.22(249A) PACE organization application and waiver process.** This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

**88.22(1) Application requirements.** A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: [http://www.cms.hhs.gov/PACE/06\\_ProviderApplicationandRelatedResources.asp](http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp).

*a.* The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

*b.* Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

**88.22(2) Waiver of federal requirements.** A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

*a.* The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or

(2) At any time during the approval process.

*b.* The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

**88.22(3)** *Review of applications and requests for waiver of federal requirements.* The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

**88.22(4)** *Department action on applications.* Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.23(249A) PACE program agreement.** An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

**88.23(1)** *Content and terms of agreement.*

*a. Required content.* A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

*b. Optional content.* An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1)"a"(5).

(2) Contain any additional terms and conditions agreed to by the parties.

**88.23(2)** *Duration of agreement.* A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

**88.23(3) Enforcement of agreement.** If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

- a. Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.
- b. Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.
- c. Terminate the PACE program agreement.

**88.23(4) Termination of agreement by the department.**

a. *Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

b. *Notice and opportunity for hearing.* Except as provided in paragraph “c” of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department’s determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

c. *Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph “b” of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

**88.23(5) Termination of agreement by PACE organization.** A PACE organization may terminate an agreement after timely notice issued as follows:

a. To CMS and the department, 90 days before termination.

b. To enrollees, 60 days before termination.

**88.23(6) Transitional care during termination.** A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee’s medical records available to new providers.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.24(249A) Enrollment and disenrollment.** A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

**88.24(1) Eligibility for Medicaid enrollees.** To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

a. *Basic eligibility requirements.*

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE organization.

(3) The person must be eligible for Medicaid pursuant to the provisions in 441—Chapter 75 for persons in a medical institution.

(4) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.

(5) The department must determine that the person needs the nursing facility level of care.

(6) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

*b. Other eligibility requirements.*

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety, pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.24(4).

**88.24(2) *Effective date of enrollment.*** A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

**88.24(3) *Duration of enrollment.*** Enrollment continues until the enrollee's death unless either of the following actions occurs:

*a.* The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

*b.* The enrollee is involuntarily disenrolled, as described in subrule 88.24(5).

**88.24(4) *Annual recertification.***

*a.* At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

*b.* Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

**88.24(5) *Involuntary disenrollment.*** An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

*a. Reasons for involuntary disenrollment.* An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.28(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.24(5) "b."

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.24(4) "b."

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

*b. Disruptive or threatening behavior.* “Disruptive or threatening behavior” refers to either of the following:

- (1) Behavior that jeopardizes the enrollee’s health or safety or the safety of others; or
- (2) Consistent refusal by the enrollee to comply with the enrollee’s individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

*c. Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee’s medical record:

- (1) The reasons for proposing to disenroll the enrollee.
- (2) All efforts to remedy the situation.

*d. Noncompliant behavior.* A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee’s behavior jeopardizes the enrollee’s health or safety or the safety of others. “Noncompliant behavior” includes repeated noncompliance with medical advice and repeated failure to keep appointments.

**88.24(6) Effective date of disenrollment.**

*a.* In disenrolling a Medicaid enrollee, the PACE organization must:

- (1) Use the most expedient process allowed under the PACE program agreement;
- (2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and
- (3) Give reasonable advance notice to the enrollee.

*b.* Until the date when enrollment is terminated, the following requirements must be met:

- (1) The PACE organization must continue to furnish all needed services.
- (2) The enrollee must continue to use PACE organization services.

**88.24(7) Documentation of disenrollment.** A PACE organization must meet the following requirements:

- a.* Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.
- b.* Make documentation available for review by CMS and the department.
- c.* Use the information on voluntary disenrollments in the PACE organization’s internal quality assessment and performance improvement program.

**88.24(8) Reinstatement in other Medicare and Medicaid programs.** After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee’s reinstatement in other Medicare and Medicaid programs by:

- a.* Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and
- b.* Ensuring that medical records are made available to new providers in a timely manner.

**88.24(9) Reinstatement in PACE.** A previously disenrolled enrollee may be reinstated in a PACE program.

[ARC 0758C, IAB 5/29/13, effective 8/1/13; ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.25(249A) Program services.** A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

**88.25(1) Required services.** The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

- a.* All Medicare-covered items and services.
- b.* All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.
- c.* Other services determined necessary by the enrollee’s interdisciplinary team to improve or maintain the enrollee’s overall health status.

**88.25(2) Excluded services.** The following services are excluded from coverage under PACE:

a. Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.

b. In an inpatient facility:

(1) A private room and private-duty nursing services unless medically necessary; and

(2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.

c. Cosmetic surgery. "Cosmetic surgery" does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

d. Experimental medical, surgical, or other health procedures.

e. Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

**88.25(3) Service delivery.** The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

a. *Provision of services.* PACE services must be furnished in at least:

(1) The PACE center,

(2) The enrollee's home, and

(3) Inpatient facilities.

b. *PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

**88.25(4) Minimum services furnished at a PACE center.** At a minimum, the following services must be furnished at each primary or alternate PACE center:

a. Primary care, including physician and nursing services.

b. Social services.

c. Restorative therapies, including physical therapy and occupational therapy.

d. Personal care and supportive services.

e. Nutritional counseling.

f. Recreational therapy.

g. Meals.

**88.25(5) Primary care.** Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

a. Managing an enrollee's medical situations; and

b. Overseeing an enrollee's use of medical specialists and inpatient care.

**88.25(6) Out-of-network emergency care.** A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

a. *Definitions.* As used in this subrule, the following definitions apply:

"*Emergency medical condition*" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the enrollee.
2. Serious impairment to bodily functions of the enrollee.
3. Serious dysfunction of any bodily organ or part of the enrollee.

*“Emergency services”* means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization’s service area.

*“Poststabilization care”* means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

*“Urgent care”* means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service area but that does not meet the definition of emergency services because the enrollee’s life or functioning is not in severe jeopardy.

*b. Plan.* A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.
2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

*c. Explanation to enrollee.* The organization must ensure that the enrollee or caregiver, or both, understand:

- (1) When and how to access out-of-network emergency services, and
- (2) That no prior authorization is needed.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.26(249A) Access to PACE services.** An enrollee’s access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee’s health and social status.

**88.26(1) Interdisciplinary team.** A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

*a. Team composition.* The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master’s-level social worker.
- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) PACE center manager.
- (9) Home care coordinator.
- (10) Personal care attendant or attendant’s representative.
- (11) Driver or driver’s representative.

*b. Team responsibilities.* Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

- (1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.
- (2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.
- (3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

*c. Exchange of information.* The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

**88.26(2) Initial assessment.** The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

*a.* Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) Home care coordinator.

*b.* At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

*c.* The assessment of each enrollee must include, but not be limited to, assessment of the following:

- (1) Physical and cognitive function and ability.
- (2) Medication use.
- (3) Enrollee and caregiver preferences for care.
- (4) Socialization and availability of family support.
- (5) Current health status and treatment needs.
- (6) Nutritional status.
- (7) Home environment, including home access and egress.
- (8) Enrollee behavior.
- (9) Psychosocial status.
- (10) Medical and dental status.
- (11) Enrollee language.

**88.26(3) Plan of care.** The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

*a. Development.* The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

*b. Content.* The plan of care must:

- (1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

- (2) Identify measurable outcomes to be achieved.
- c. Documentation.* The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.
- d. Implementation.* The interdisciplinary team shall:
  - (1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and
  - (2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.
- e. Evaluation.* On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

**88.26(4) Reassessment.**

*a. Semiannual reassessment.* On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Recreational therapist or activity coordinator.
- (5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

*b. Annual reassessment.* On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Physical therapist.
- (2) Occupational therapist.
- (3) Dietitian.
- (4) Home care coordinator.

*c. Unscheduled reassessments.* In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

- (1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.26(2) "a" must conduct an in-person reassessment.
- (2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

*d. Changes to plan of care.* Interdisciplinary team members who conduct a reassessment must:

- (1) Reevaluate the enrollee's plan of care.
- (2) Discuss any changes in the plan of care with the interdisciplinary team.
- (3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.
- (4) Document all assessment and reassessment information in the enrollee's medical record.
- (5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

**88.26(5) Procedures for resolving enrollee request to change the plan of care.** The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

*a.* Except as provided in paragraph "b" of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

*b.* The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

- (1) The enrollee or designated representative requests the extension; or
- (2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

*c.* The PACE organization must:

- (1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and
- (2) Provide the specific reasons for the denial in understandable language.

*d.* The PACE organization is responsible for:

- (1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.
- (2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.
- (3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

*e.* If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

*f.* The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.27(249A) Program administrative requirements.** A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

**88.27(1) Enrollee rights.** A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

**88.27(2) Data collection, record maintenance, and reporting.** A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

**88.27(3) Quality assessment and performance improvement.** A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

**88.27(4) Federal and state monitoring.**

*a.* The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

- (1) Corrective action required pursuant to 42 CFR Section 460.194; and
- (2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

*b.* The PACE program is subject to sanctions or termination pursuant to subrules 88.23(3) and 88.23(4).

c. During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division II.

d. After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

e. After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

f. Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

g. CMS or the department shall monitor the effectiveness of the corrective actions implemented.  
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.28(249A) Payment.**

**88.28(1) Medicaid payment to PACE organization.** Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

a. The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

**88.28(2) Liability of Medicaid enrollee.** A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

a. *Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

b. *Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

These rules are intended to implement Iowa Code section 249A.4.

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<sup>◇</sup> Two or more ARCs

<sup>1</sup> Effective date of 8/1/88 delayed 30 days by the Administrative Rules Review Committee at its July 1988 meeting.

<sup>2</sup> 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.



CHAPTER 90  
TARGETED CASE MANAGEMENT

PREAMBLE

These rules define and structure medical assistance targeted case management services provided in accordance with Iowa Code section 225C.20 for Medicaid members with an intellectual disability, a chronic mental illness, or a developmental disability and members eligible for the home- and community-based services (HCBS) children's mental health waiver. Provider accreditation standards are set forth in 441—Chapter 24.

Case management is a method to manage multiple resources effectively for the benefit of Medicaid members. The service is 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.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 2164C, IAB 9/30/15, effective 10/1/15]

**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.

*“Child”* means a person under 18 years of age.

*“Chronic mental illness”* means the 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.

People with chronic mental illness typically meet at least one of the following criteria:

1. They 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. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.

2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.

3. They show severe inability to establish or maintain a personal social support system.

4. They require help in basic living skills.

5. They 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 these criteria could still be considered to be a person with chronic mental illness.

For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

*“Department”* means the department of human services.

*“Developmental disability”* means a severe, chronic disability 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: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and 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.

*"Intellectual disability"* means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which:

1. Is made only when the onset of the person's condition was during the developmental period;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills; and
4. Is made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

*"Major incident"* means an occurrence involving a member using the service that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; or
2. Results in a member's death or the death of another person; or
3. Requires emergency mental health treatment for the member; or
4. Requires the intervention of law enforcement; or
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3."
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

*"Medical institution"* means an institution that is organized, staffed, and authorized to provide medical care as set forth in 42 Code of Federal Regulations 435.1009, as amended to October 1, 2001. 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.

*"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 person may share a residence.

*"Targeted case management"* means services furnished to assist members who are part of a targeted population and 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 services in order to ensure the health, safety, and welfare of the members. Case management is provided to a member on a one-to-one basis by one case manager.

*"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 or HCBS children's mental health waiver services according to 441—Chapter 83.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—90.2(249A) Eligibility.** A person who meets all of the following criteria shall be eligible for targeted case management:

- 90.2(1)** The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35).
- 90.2(2)** The person is a member of the targeted population.
- 90.2(3)** The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.5(3).
- 90.2(4)** The person has applied for targeted case management in accordance with the policies of the provider.

**90.2(5)** The person's need for targeted case management has been determined in accordance with rule 441—90.3(249A).

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

**441—90.3(249A) Determination of need for service.**

**90.3(1)** *Authorization required.* Rescinded IAB 7/15/09, effective 7/1/09.

**90.3(2)** *Need for service.* Assessment of the need for targeted case management is required at least annually as a condition of payment under the medical assistance program. The case management provider shall determine the 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 needed 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.

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

**90.3(3)** *Managed health care.* Rescinded IAB 1/6/16, effective 1/1/16.

**90.3(4)** *Transition authorization.* Rescinded IAB 7/15/09, effective 7/1/09.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—90.4(249A) Application.** 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 if other services are needed or requested.

**90.4(1)** *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. 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 agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

**90.4(2)** *Application decision.* The provider shall inform the applicant or the applicant's legally authorized representative of any decision to approve, deny, or delay the service in accordance with notification requirements at 441—subrule 7.7(1).

**90.4(3)** *Delayed services.* The application shall be approved and the member put on the referral list for assignment to a case manager when targeted case management cannot begin immediately because there is no opening on a caseload. The provider shall notify the applicant or the applicant's legally authorized representative in writing of approval and placement on the referral list. If an applicant is on a referral list for more than 90 days from the date of application, this shall be considered a denial of service.

**90.4(4)** *Denying applications.* The provider shall deny applications for service when:

a. The applicant is not currently eligible for Medicaid; or

b. The applicant does not meet the eligibility criteria in rule 441—90.2(249A); or

c. The applicant or the applicant's legally authorized representative withdraws the application; or

d. The applicant does not provide information required to process the application; or

e. The applicant is receiving targeted case management from another Medicaid provider; or

f. The applicant does not have a need for targeted case management.

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

**441—90.5(249A) Service provision.**

**90.5(1)** *Covered services.* The following shall be included in the assistance that case managers provide to members in obtaining services:

a. *Assessment.* The case manager shall perform a comprehensive assessment and periodic reassessment of the member's individual needs using Form 470-4694, Targeted Case Management

Comprehensive Assessment, to determine the need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:

(1) Taking the member's history, including current and past information and social history in accordance with 441—subrule 24.4(2), and updating the history annually.

(2) Identifying the needs of the member and completing related documentation.

(3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.

*b. Service plan.* The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop the goals. This plan shall:

(1) Document the parties participating in the development of the plan.

(2) Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.

(3) Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.

(4) Document services identified to meet the needs of the member which the member declined to receive.

(5) Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:

1. Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.

2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change. The interdisciplinary team shall determine which of the following options will be included in the crisis intervention plan:

- After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or

- After-hours contact information for an on-call system for the provider of case management to ensure that in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays.

(6) Include a discharge plan.

(7) Be revised at least annually, and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

*c. Referral and related activities.* The case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link 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 service plan.

*d. Monitoring and follow-up.* The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the 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. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

(1) Services are being furnished in accordance with the member's 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 is occurring among all providers to ensure coordination of services.

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

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

*e. Contacts.* Case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

(1) The case manager shall have at least one face-to-face contact with the member every three months.

(2) The case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other entities or individuals. This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, E-mail, and fax, when the written communication directly pertains to the needs of the member. E-mail contacts are allowed only when other means of communication are not feasible for the member, representative or family and the necessity for E-mail communication is documented in the member's comprehensive service plan. A copy of any written communication must be maintained in the case file. When E-mail communication is used, there must be clear two-way communication in the member's record showing an exchange of information as well as follow-up activity related to the information.

(3) The case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member access services, identifying needs and supports to assist the member in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the member's needs.

(4) When applicable, documentation of case management contacts shall include:

1. The name of the service provider.

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

**90.5(2) Exclusions.** Payment shall not be made for activities otherwise within the definition of case management when any of the following conditions exist:

*a.* The activities are an integral component of another covered Medicaid service, including but not limited to assertive community treatment (ACT).

*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.

(5) Foster care programs.

*c.* The activities are integral to 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) Home investigations.

(6) Providing transportation.

(7) Administering foster care subsidies.

(8) Making placement arrangements.

*d.* The activities for which a member may be eligible are integral to 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.

**90.5(3) *Transition to a community setting.*** 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 under a targeted population. Transitional case management is not an allowable service under the HCBS brain injury waiver, the HCBS elderly waiver, or HCBS habilitation services.

*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 plan of care, 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 community case management providers.

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

**90.5(4) *Rights restrictions.*** Member rights may be restricted only with the consent of the member or the member's legally authorized representative and only if the service plan includes:

*a.* Documentation of why there is a need for the restriction;

*b.* A plan to restore those rights or a reason why restoration is not necessary or appropriate; and

*c.* Documentation that periodic evaluations of the restriction are conducted to determine continued need.

**90.5(5) *Documentation.*** Service documentation shall also meet the requirements set forth in rule 441—79.3(249A) and 441—subrule 24.4(4).

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9588B, IAB 6/29/11, effective 9/1/11]

#### **441—90.6(249A) Terminating services.**

**90.6(1)** Targeted case management shall be terminated when:

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

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

*c.* The member has no current need for targeted case management; or

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

*e.* The member or the member's legally authorized representative requests termination; or

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

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

**90.6(2)** The provider shall notify the member or the member's legally authorized representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

#### **441—90.7(249A) Appeal rights.**

**90.7(1) *Appeal to the provider.*** After notice of an adverse decision by the provider of targeted case management, the member or the member's representative may request an appeal as provided in the appeal process established by the provider agency.

**90.7(2) *Appeal to the department.*** After notice of an adverse decision by the department pertaining to authorization and need for service, the member or the member's representative may request reconsideration by the department by sending a letter to the department not more than 30 days after

the date of the notice of adverse decision. The member or the member's representative may appeal an adverse reconsideration decision by the department as provided in 441—Chapter 7.

**90.7(3) *Appeal to the managed health care contractor.*** After notice of an adverse decision by a managed health care plan, the member or the member's representative may request a review as provided in rule 441—88.68(249A).

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

**441—90.8(249A) Provider requirements.**

**90.8(1) *Incident reporting.***

*a.* When a major incident occurs during the provision of case management services:

(1) The case management provider shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The case management supervisor.
2. The member's legally authorized representative.

(2) By the end of the next calendar day after the incident, the case manager who observed the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all case management 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 members or nonmembers who were present must be maintained by the use of initials or other means.
5. The action that the case manager took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) The case manager shall monitor the situation as required in paragraph 90.5(1) "d" to ensure the member's needs continue to be met. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager.

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

*b.* When an incident report for a major incident is received from any provider, the case manager shall monitor the situation as required in paragraph 90.5(1) "d" to ensure 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 comprehensive assessment as required in paragraph 90.5(1) "a" in order to ensure the continued health, safety, and welfare of the member.

**90.8(2) *Emergency coverage.*** Rescinded IAB 6/29/11, effective 9/1/11.

**90.8(3) *Quality assurance.*** Providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

- a.* Postpayment reviews 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.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 2361C, IAB 1/6/16, effective 1/1/16]

These rules are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27.

[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]<sup>1</sup>

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[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]

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[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

<sup>1</sup> 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.

CHAPTER 92  
IOWACARE

Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16



TITLE XIV  
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150  
PURCHASE OF SERVICE

[Prior to 7/1/83, Social Services[770] Ch 145]  
[Previously appeared as Ch 145—renumbered IAB 2/29/84]  
[Prior to 2/11/87, Human Services[498]]

DIVISION I  
TERMS AND CONDITIONS FOR IOWA PURCHASE OF SOCIAL SERVICES AGENCY AND  
INDIVIDUAL CONTRACTS, IOWA PURCHASE OF ADMINISTRATIVE SUPPORT, AND  
IOWA DONATIONS OF FUNDS CONTRACT AND PROVISIONS FOR PUBLIC ACCESS TO CONTRACTS

**441—150.1(234) Definitions.**

*“Accounting year”* means a 12 consecutive month period for which accounting records are maintained. It can be either a calendar year or another designated fiscal year.

*“Accrual basis accounting”* means the accounting basis which shows all expenses incurred and income earned for a given time even though the expenses may not have been paid or income received in cash during the period.

*“Administrative support”* means technical assistance, studies, surveys, or securing volunteers to assist the department in fulfilling its administrative responsibilities.

*“Agency”* means an organization or organizational unit that provides social services.

1. Public agency means a general or special-purpose unit of government and organizations administered by that unit to deliver social services, for example, county boards of supervisors, community colleges, and state agencies.

2. Private nonprofit agency means a voluntary agency operated under the authority of a board of directors for purposes other than generating profit and incorporated under Iowa Code chapter 504A. An out-of-state agency must meet requirements of similar laws governing nonprofit organizations in its state.

3. Private proprietary agency means a for-profit agency operated by an owner or board for the operator’s financial benefit.

*“Bureau of purchased services”* means a bureau of the division of fiscal management, which is responsible for administering the purchase of service system.

*“Cash basis accounting”* means the accounting basis which records expenses when bills are paid and income when money is received.

*“Ceiling”* means the maximum limit for payment for a service which has been established by an administrative rule or by the Iowa Code specifically for that service.

*“Client”* means an individual or family group who has applied for and been found to be eligible for social services from the Iowa department of human services.

*“Common ownership”* means that relationship existing when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

*“Components of service”* means the elements or activities that make up a specific service.

*“Contract”* means formal written agreement between the Iowa department of human services and another legal entity, except for those government agencies whose services are covered under provision of Iowa Code chapter 28E.

*“Contractor”* means an institution, organization, facility or individual who is a legal entity and has entered into a contract with the department of human services.

*“Control”* means that relationship existing where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

*“Department”* means the Iowa department of human services.

*“Direct cost”* means those expenses which can be identified specifically and solely to a particular program.

*“Donor”* means a local source of funding (public or private) that enters into an Iowa donation of funds contract.

*“Effective date.”*

1. Contract effective date for agency contracts means the first day of a month on which the contract shall become in force.

2. Effective date of rate means the date specified in a purchase of service contract on which the specified rate of payment for service provided begins.

*“Field staff”* means department employees outside of central office reporting to the deputy director of field operations.

*“Grant”* means an award of funds to develop specific programs or achieve specific outcomes.

*“Indirect cost”* means those expenses which cannot be related directly to a specific program and are, therefore, allocated to more than one program.

*“Project manager”* means a department employee who is assigned to assist in developing, monitoring and evaluating a contract and to provide related technical assistance.

*“Provider”* means an institution, organization, facility, or individual who is a legal entity and has entered into a contract with the department to provide social services to clients of the department.

*“Purchase of service system”* means the system within the department for contracting and payment for services, including contracts for funding and contracts for technical assistance.

*“Related to provider”* means that the provider to a significant extent is associated or affiliated with or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

*“Relatives”* include the following persons: husband and wife, natural parent and child, sibling, adopted child and adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent and grandchild.

*“Social services”* means a set of actions purposefully directed toward human needs which are socially identified as requiring assistance from others for their resolution.

*“Unit of service”* means a specified quantity of service or a specific outcome as a result of the service provided.

**441—150.2(234) Categories of contracts.**

**150.2(1)** *Iowa purchase of social services contract.* An Iowa purchase of social services contract is a legal contract between the department and a provider for a specified service or services to clients referred by the department. This contract establishes the components of service to be provided, the rate per unit of service, a maximum number of units to be available, and other negotiated conditions. The department has three types of contracts for purchasing social services.

*a.* An agency contract is a contract written with an agency. Iowa Purchase of Social Services Agency Contract, Form 470-0628, shall be completed prior to services being purchased from the agency.

*b.* A child care certificate is an agreement written with a licensed child care center, a family day care home, a group day care home, an in-home care provider, or a relative care provider. Policies governing child care certificates may be found in 441—Chapter 170.

*c.* An individual in-home health-related provider agreement is an agreement written with an individual provider of in-home health services. Policies governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

**150.2(2)** *Iowa purchase of administrative support contract.* An Iowa purchase of administrative support contract is between the department and a contractor for the provision of administrative support. This contract establishes the support services to be provided, the rate and the method of payment, and other negotiated conditions. A contractor or the division of a contractor who is a multiservice organization holding an administrative support contract may not provide direct client services during the period of the contract.

*a.* A volunteer contract is the administrative support contract between an individual or agency and the department to secure volunteers to assist the department in service delivery.

*b.* A general use administrative support contract is between the department and a contractor for the provision of administrative support.

**150.2(3)** *County board of supervisors’ participation contract.* Rescinded IAB 7/8/92, effective 7/1/92.

**150.2(4) Iowa donation of funds contract.** The department may accept donated funds.

*a.* Upon mutual agreement regarding the scope and use of the funds to be donated, the department may negotiate and shall execute a contract between the department and the donor in accordance with department of administrative services rules in 11—Chapters 106 and 107. The contract shall contain specifications concerning amendment, termination, transmittal of funds, accounting, and reversion of unspent funds.

*b.* Except for restrictions permitted by the contract, all funds shall be donated on an unrestricted basis for use as if they were appropriated funds and shall be under the administrative control of the department. The donor may specify the geographic area to be served and the specific service to be provided.

*c.* No funds donated and transmitted to the department will be returned to the donor unless specified in the contract.

**441—150.3(234) Iowa purchase of social services agency contract.**

**150.3(1) Initiation of contract proposal.** When the department issues a request for proposal to select providers, the process and conditions for approving contract proposals shall be as specified in the request, and the department shall not be required to contract with a provider that is not selected. Otherwise, the following procedures for initiation of contract proposals shall apply.

*a. Right to request a contract.* All potential provider agencies have a right to request a contract.

*b. Initial contact.* The initial contact should be between the potential provider and the service area manager for the service area in which the provider's headquarters is located. In the case of out-of-state providers, this contact can be with the service area manager for either the closest service area or the service area initiating the contact. At the beginning of the process of developing a contract, the bureau of purchased services shall give the provider:

- (1) Information about the contracting process; and
- (2) Instructions on how to access the Purchase of Service Provider Handbook electronically.

*c. Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This information shall include documentation that the conditions of participation are met. Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, shall be completed at the same time as Form 470-0628, Iowa Purchase of Social Services Agency Contract, or Form 470-0630, Amendment or Renewal of the Iowa Purchase of Social Services Agency Contract, is prepared.

*d. Contract proposal approval or rejection.* Before a contract can be effective, it shall be signed by the following persons within the time frames provided:

- (1) Authorized representative of the provider agency.
- (2) Service area manager, within one week from receipt.
- (3) Rescinded IAB 5/11/05, effective 5/1/05.
- (4) Chief of the bureau of purchased services, within 30 days from receipt.

The provider shall be given a notice and explanation in writing of delays in the process or of rejection of the proposal. Payment cannot be made until the contract is signed by the provider's authorized representative and the chief of the bureau of purchased services.

*e. Criteria for rejection.* The following criteria may cause a proposed contract to be rejected:

- (1) The service is not needed by department clients.
- (2) The service is not in the social services block grant plan for the counties to be served by the program.
- (3) No funds are available for the service being proposed.
- (4) The proposed contract does not meet applicable rules, regulations, or guidelines, including service definition.

*f. Contract effective date.* When the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the chief of the bureau of purchased services.

**150.3(2) Contract administration.**

*a. Contract management.* During the contract period the assigned project manager shall be the contract liaison between the department and the provider. The project manager shall be contacted on all interpretations and problems relating to the contract and shall follow the issues through to their resolution. The project manager shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance, if needed. Report of On-Site Visit, Form 470-0670, may be used to monitor performance under the contract.

*b. Contract amendment.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of services shall include reestablishment of applicable rates. Amendment or Renewal of Iowa Purchase of Social Services Agency Contract, Form 470-0630, shall be used to amend or renew the contract.

*c. Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days before the expiration date.

(1) Each contract shall be evaluated. The department shall take the results of the evaluation into consideration in making the decision on renewal. This evaluation may involve use of the Monitoring and Evaluation Review Guide, Form 470-2571, or other evaluation tools specified in the contract.

(2) Desk Audit for Civil Rights Contract Compliance, Form 470-2215, shall be completed by the provider.

*d. Contract termination.* Causes for termination during the period of the contract are:

- (1) Mutual agreement of the parties involved.
- (2) Demonstration that sufficient funds are unavailable to continue the services involved.
- (3) Failure to make required reporting.
- (4) Failure to make financial and statistical records available for review.
- (5) Failure to abide by the provisions of the contract.

**150.3(3) Conditions of participation.** The provider shall meet the following standards:

*a. Licensure, approval, or accreditation.* The provider shall have any license, approval, and accreditation required by law, regulation or administrative rules, or standards of operation required by the state or the federal government before the contract can be effective. Out-of-state providers shall meet Iowa licensing standards related to treatment, professional staff to client ratio, and staff qualifications.

*b. Signed contract.* A contract can be effective only when signed by all parties required in 150.3(1) "d."

*c. Civil rights laws.* The providers shall be in compliance with all federal, state and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*d. Title VI compliance.* The provider shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*e. Section 504 compliance.* The provider shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, Plan Review Accessibility Checklist, Form 470-0149, and Section 504 Transition Plan: Structural Accessibility, Form 470-0150, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*f. Affirmative action.* The provider shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*g. Abuse reporting.* The provider shall have a written policy and procedure approved by the service area manager or designee for reporting abuse or denial of critical care of children or dependent adults.

*h. Confidentiality.* The provider shall comply with all applicable federal and state laws and regulations on confidentiality including rules on confidentiality contained in 441—Chapter 9. The provider shall have a written policy and procedure approved by the service area manager or designee for maintaining individual client confidentiality including client record destruction.

*i. Client appeals and grievances.* Clients receiving service through a purchase of service contract have the right to appeal adverse decisions made by the department or the provider. The provider shall have a written policy and procedure approved by the service area manager or designee for handling client appeals and grievances and shall provide information to clients about their rights to appeal.

*j. Client reports.* The provider shall maintain the following client records:

(1) Provider service plan or individual program plan. Providers shall develop a written service plan or individual program plan for each client within 30 days of service initiation. The plan shall include a concise description of the situation or area which will be the focus of the service; statement of the goals to be achieved through the delivery of services; time limited and measurable objectives which will lead to the attainment of the goal to be achieved; specific service components, frequency, and the assignment of responsibility for the provision of the components; and the month and year when it is estimated the client will be able to achieve the current goals and objectives. The provider service plan shall be updated upon receipt of a new departmental case plan, but at least once every six months.

(2) Quarterly progress reports. Quarterly progress reports shall be sent to the department service worker responsible for the client. The first report shall be submitted to the department three months after service is initiated. Reports shall be submitted quarterly thereafter, unless provided for otherwise in rules for a specific service.

The progress report shall include a description of the specific service components provided, their frequency, and who provided them; the client's progress with respect to the goals and service objectives; and any recommended changes in the service plan or individual program plan. For all placement cases the report shall include interpretation of the client's reaction to placement, a summary of medical or dental services that were provided, a summary of educational or vocational progress and participation, and a summary of the involvement of the family with the client and the services.

Reports for the supervised apartment living service shall also include supporting documentation for service provision. The documentation shall list dates of client and collateral contacts, type of contact, persons contacted, and a brief explanation of the focus of each contact. Each unit of service for which payment is sought should be the subject of a written progress note.

(3) Termination of service summary. A termination of service summary shall be sent to the department service worker responsible for the client within two weeks of service termination. The summary shall include the rationale for service termination and the impact of the service components on the client in relationship to the established goals and objectives.

*k. Financial and statistical records.* Each provider of service must maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, and state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

*l. Reports on financial and statistical records.* Reports on financial and statistical records shall be submitted as required. Failure to do so within the required time limits is grounds for termination of the contract.

*m. Maintenance of client records.* Records for clients served through a purchase of service contract must be retained by the provider for a period of three years after service to the client terminates.

*n. Provider charges.* A provider shall not charge department clients more than it receives for the same services provided to nondepartmental clients.

*o. Special-purpose organizations.* A provider may establish a separate, special-purpose organization to conduct certain of the provider's client-related or nonclient-related activities. For example, a development foundation assumes the provider's fund-raising activity. Often, the provider does not own the special-purpose organization (e.g., a nonprofit, nonstock-issuing corporation), and has no common governing body membership. However, a special-purpose organization is considered to be related to a provider if:

(1) The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies; or

(2) The provider is, for all practical purposes, the primary beneficiary of the organization's activities. The provider should be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with intent of benefiting the provider.

The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider; or

The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

*p. Certification by department of transportation.*

(1) If the provider furnishes public transit service as defined in 761—910.1(324A), the provider shall annually submit to the project manager information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

1. Form 020107, Certification Application for Coordination of Public Transit Services, which the project manager shall submit to the department of transportation; and

2. A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

(2) If a provider believes it does not furnish public transit service as defined in 761—910.1(324A) and therefore is exempt from the requirements in subparagraph (1), the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

(3) If a provider that has furnished public transit service as defined in 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in subparagraph (1).

(4) If an exempt provider begins to furnish public transit service as defined in 761—910.1(324A), the provider shall inform the project manager within 30 days of the change and shall adhere to the procedures in subparagraph (1).

(5) Failure of the provider to cooperate in obtaining or providing the required documentation for compliance or exemption is grounds for denial or termination of the contract.

*q. Services provided.* Services provided, as described in Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, and attachments, shall at a minimum meet the rules found in the Iowa Administrative Code for a particular service or the contract may be terminated.

*r. Bonding, indemnity and insurance clauses.*

(1) Rescinded IAB 2/3/93, effective 4/1/93.

(2) Indemnity. The provider agrees that it will at all times during the existence of this contract indemnify and hold harmless the department and county against any and all liability, loss, damages, costs or expenses which the provider may hereafter sustain, incur or be required to pay:

1. By reason of any client's suffering personal injury, death or property loss or damages either while participating in or receiving from the provider the care and services to be furnished by the provider under this contract, or while on premises owned, leased, or operated by the provider, or while being

transported in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the provider or any officer, agency, or employee thereof.

2. By reason of any client's causing injury to or damage to another person or property during any time when the provider or any officer, agency or employee thereof has undertaken or is furnishing the care and service called for under this contract.

(3) Insurance. The provider agrees that in order to protect itself as well as the department and county under the indemnity agreement above, it will at all times during the term of the contract have and keep in force a liability insurance policy, verification of which shall accompany Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet. The provider agrees that all employees, volunteers, or any other person, other than employees of the department acting within the scope of their employment in the department, authorized to transport clients in privately owned vehicles, have liability insurance in force.

*s. Renegotiation clause.* In the event there is a revision of federal or state laws or regulations and this contract no longer conforms to those laws or regulations, both parties will review the contract and renegotiate those items necessary to conform with the new federal or state laws or regulations.

*t. Performance measures.* The department may require performance measures.

**150.3(4) Establishment of rates.** The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, is the basis for establishing the rates to be paid to all providers under an Iowa Purchase of Social Services Agency Contract, Form 470-0628, except as provided below.

*a. Injectable contraceptive unit.* Rescinded IAB 8/1/07, effective 9/5/07.

*b. Out-of-state providers.*

(1) Rescinded IAB 9/1/93, effective 11/1/93.

(2) Out-of-state providers of other services shall have rates established using the applicable portions of the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664.

*c. Family-centered flexible supportive services.* Rescinded IAB 5/6/09, effective 7/1/09.

**150.3(5) Financial and statistical report.** The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, shall be completed by those providers as required in 150.3(4). The reports shall be based on the following rules.

*a. Accounting procedures.* 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 who are multiple program agencies shall submit a cost allocation schedule prepared in accordance with recognized methods and procedures.

(1) Direct program expense shall include all direct client contact personnel involved in a program including the time of a supervisor of a program, or the apportioned share of the supervisor's time when the supervisor supervises more than one program.

(2) Expenses other than salary and fringe benefits shall be charged as direct program expenses when the expenses are identifiable to a program. They may also be charged as direct program expenses when a method of distribution acceptable to the department is maintained on a consistent basis.

(3) Occupancy expenses shall be allocated to programs on a space utilization formula. The space utilization formula may be used for salaries and fringes of building maintenance and janitorial type personnel.

(4) All expenses which relate jointly to two or more programs shall be allocated to program service costs by utilizing a cost allocation method which fairly distributes costs to the related programs. Any expenses which relate directly to a particular program shall be reflected as such. All maintenance costs shall be charged directly or allocated proportionately to the related programs affected.

(5) Indirect program service costs shall be distributed over all applicable services.

(6) Expenses such as supplies, conferences, and similar expenses that cannot be directly related to a program shall be charged to indirect program service costs.

(7) A multiservice agency shall establish a method acceptable to the department of distributing indirect program service costs.

(8) Income received from fund-raising efforts or donations shall be reported as revenue on the financial and statistical report and used to offset fund-raising costs. Fund-raising costs remaining after the offset shall be an unallowable cost.

All contributions shall be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included by the department in its reimbursement rate determination unless these moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the department.

If a shelter care provider's actual and allowable costs for a child's shelter care placement exceed the amount the department is authorized to pay and the provider is reimbursed by the child's county of legal settlement for the difference between actual and allowable costs and the amount reimbursed by the department, the amount paid by the county shall not be included by the department in its reimbursement rate determination, as long as the amount paid is not greater than the provider's actual and allowable costs, or the statewide average of actual and allowable costs in May of the preceding year for juvenile shelter care homes, whichever is less.

(9) When an agency has a certified public accounting firm perform an audit of its financial statements, the resulting audit report shall follow one of the uniform audit report formats recommended by the American Institute of Certified Public Accountants. These formats are specified in the industry audit guide series, "Audits of Voluntary Health and Welfare Organizations," prepared by the Committee on Voluntary Health and Welfare Organizations, American Institute of Certified Public Accountants, New York, 1974. A copy of the certified audit report shall be submitted to the department within 60 days of receipt.

(10) All expenses reported on Form 470-0664 shall be supported by an agency's general ledger and documentation on file in the agency's office.

*b. Failure to maintain records.* Failure to maintain records adequate to support the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, may result in termination of the contract. These records include, but are not limited to:

- (1) Reviewable, legible census reports.
- (2) Payroll information.
- (3) Capital asset schedules.
- (4) All canceled checks, deposit slips, invoices (paid and unpaid).
- (5) Audit reports (if any).
- (6) Board of directors' minutes.

*c. Submission of reports.* The financial and statistical report shall be submitted to the department no later than three months after the close of the provider's established fiscal year. At least one week must be allowed prior to this deadline for the project manager to review the report and transmit it to the bureau of purchased services in central office. Failure to submit the report in time without written approval from the chief of the bureau of purchased services may reduce payment to 75 percent of the current rate. Failure to submit the report within six months of the end of the fiscal year shall be cause for terminating the contract.

*d. Rate modification.* Modification of rates shall be made when required by changes in licensing requirements, changes in the law, or amendments to the contract. Requests for modification of a rate may be made when changes are because of program expansion or modification and have the approval of the service area where services are provided. Even if there is a modification of the rate, the modified rate is still subject to any maximum established in any law or rule.

*e. Payment of new rate.* New rates shall be effective for services provided beginning the first day of the second calendar month after receipt by the bureau of purchased services of a report sufficient to establish rates or, by mutual agreement, new rates shall be effective the first day of the month following completion of the fiscal review. Failure to submit a report sufficient to establish a rate will result in the effective date's being delayed. At least one week must be allowed prior to the deadline in paragraph "c" above for the project manager to review the report and transmit it to central office.

*f. Exceptions to costs.* Exceptions to costs identified by the bureau of purchased services or its fiscal consultant will be communicated to the provider in writing.

*g. Accrual basis.* Providers not using the accrual basis of accounting shall adjust amounts to the accrual basis when the financial and statistical report is completed. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expenses.

*h. Census data.* Documentation of units of service provided which identifies the individual client shall be available on a daily basis and summarized on a monthly report. The documentation and reports shall be retained by the provider for review at the time the expenditure report is prepared and reviewed by the department's fiscal consultant.

*i. Opinion of accountant.* 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.

*j. Revenues.* When the Financial and Statistical Report is completed, revenues shall be reported as recorded in the general books and records adjusted for accruals. Expense recoveries shall be reflected as revenues.

*k. Capital asset use allowance (depreciation) schedule.* The Capital Asset Use Allowance Schedule shall be prepared using the guidelines for provider reimbursement in the Medicare and Medicaid Guide, December 1981.

*l. The following expenses shall not be allowed:*

- (1) Fees paid directors and nonworking officers' salaries.
- (2) Bad debts.
- (3) Entertainment expenses.
- (4) Memberships in recreational clubs, paid for by an agency (country clubs, dinner clubs, health clubs, or similar places) which are primarily for the benefit of the employees of the agency.
- (5) Legal assistance on behalf of clients.
- (6) Costs eligible for reimbursement through the medical assistance program.
- (7) Food and lodging expenses for personnel incurred in the city or immediate area surrounding the personnel's residence or office of employment, except when the specific expense is required by the agency and documentation is maintained for audit purposes. Food and lodging expenses incurred as part of programmed activities on behalf of clients, their parents, guardians, or consultants are allowable expenses when documentation is available for audit purposes.
- (8) Business conferences and conventions. Meeting costs of an agency which are not required in licensure.
- (9) Awards and grants to recognize board members and community citizens for achievement. Awards and grants to clients as part of treatment program are reimbursable.
- (10) Survey costs when required certification is not attained.
- (11) Federal and state income taxes.

*m. Limited service—without a ceiling.* The following expenses are limited for service without a ceiling established by administrative rule or law for that service. This includes services with maximum rates, with the exception of shelter care.

(1) Moving and recruitment are allowed as a reimbursable cost only to the extent allowed for state employees. Expenses incurred for placing advertising for purposes of locating qualified individuals for staff positions are allowed for reimbursement purposes.

(2) and (3) Rescinded IAB 5/18/88, effective May 1, 1988.

(4) Costs for participation in educational conferences are limited to 3 percent of the agency's actual salary costs, less excluded or limited salary costs as recorded on the financial and statistical report.

(5) Costs of reference publications and subscriptions for program-related materials are limited to \$500 per year.

(6) Memberships in professional service organizations are allowed to the extent they do not exceed one-half of 1 percent of the total salary costs less excluded salary costs.

(7) In-state travel costs for mileage and per diem expenses are allowable to the extent they do not exceed the maximum mileage and per diem rates for state employees for travel in the state.

(8) Reimbursement for air travel shall not exceed the lesser of the minimum commercial rate or the rate allowed for mileage in subparagraph (7) above.

(9) The maximum reimbursable salary for the agency administrator or executive director charged to purchase of service is \$40,000 annually.

(10) Annual meeting costs of an agency which are required in licensure are allowed to the extent required by licensure.

*n. Limited service—with a ceiling.* The following expenses are limited for services with a ceiling established by administrative rule or law for that service. This includes shelter care.

(1) The maximum reimbursable compensation for the agency administrator or executive director charged to purchase of service annually is \$40,000.

(2) Annual meeting costs of an agency which are required for licensure are allowed to the extent required by licensure.

*o. Establishment of ceiling and reimbursement rate.*

(1) The maximum allowable rate ceiling applicable to each service is found in the rules for that particular service.

(2) When a ceiling exists, the reimbursement rate shall be established by determining on a per unit basis the allowable cost plus the current cost adjustment subject to the maximum allowable cost ceiling.

*p. Rate limits.* Interruptions in service programs will not affect the rate. If an agency assumes the delivery of service from another agency, the rate shall remain the same as for the former agency.

(1) The combined service and maintenance reimbursement rate paid to a shelter care provider shall be based on the financial and statistical report submitted to the department. For the fiscal year beginning July 1, 2015, the maximum reimbursement rate shall be \$101.83 per day, based on a 365-day year. If the department reimburses the provider at less than the maximum rate, the department shall adjust the provider's reimbursement rate to the provider's actual and allowable cost plus the inflation factor or to the maximum reimbursement rate, whichever is less.

(2) The initial reimbursement rate for any new service shall be based upon actual and allowable costs. A new service does not include a new building or location or other changes in method of service delivery for a service currently provided under the contract.

1. For shelter care, if the provider is currently offering shelter care under social services contract, the only time the provider shall be considered to be offering a new service is if the provider adds a service other than shelter care.

2. For supervised apartment living, the only time a provider shall be considered to be offering a new service is when the agency adds a cluster site or a scattered site for the first time. If, for example, the agency has a supervised apartment living cluster site, the addition of a new site does not constitute a new service.

3. If the department defines, in administrative rule, a new service as a social service that may be purchased, this shall constitute a new service for purposes of establishment of a rate. Once the rate for the new service is established for a provider, the rate will be subject to any limitations established by administrative rule or law.

(3) If a social service provider loses a source of income used to determine the reimbursement rate for the provider, the provider's reimbursement rate may be adjusted to reflect the loss of income, provided that the lost income was used to support actual and allowable costs of a service purchased under a purchase of service contract.

*q. Related party costs.* Direct and indirect costs applicable to services, facilities, equipment, and supplies furnished to the provider by organizations related to the provider are includable in the allowable cost of the provider at the cost to the related organization. All costs allowable at the provider level are also allowable at the related organization level, unless these related organization costs are duplicative of provider costs already subject to reimbursement.

(1) Allowable costs shall be all actual direct and indirect costs applying to any service or item interchanged between related parties, such as capital use allowance (depreciation), interest on borrowed money, insurance, taxes, and maintenance costs.

(2) When the related party's costs are used as the basis for allowable rental or supply costs, the related party shall supply documentation of these costs to the provider. The provider shall complete a

schedule displaying amount paid to related parties, related party cost, and total amount allowable. The resulting costs shall be allocated according to policies in 150.3(5) “a”(3) to (7).

Financial and statistical records shall be maintained by the related party under the provisions in 150.3(3) “k.”

(3) Tests for relatedness shall be those specified in rule 441—150.1(234) and 150.3(3) “o.” The department or the purchase of service fiscal consultant shall have access to the records of the provider and landlord or supplier to determine if relatedness exists. Applicable records may include financial and accounting records, board minutes, articles of incorporation, and list of board members.

*r. Day care increase.* Rescinded IAB 7/7/93, effective 7/1/93.

*s. Interest on unpaid invoices.* Any invoice that remains unpaid after 60 days following the receipt of a valid claim is subject to the payment of interest. The rate of interest is 1 percent per month beyond the 60-day period, on a simple interest basis. A separate claim for the interest is to be generated by the agency. If the original claim was paid with both federal and state funds, only that portion of the original claim paid with state funds will be subject to interest charges.

*t. Interest as an allowable cost.* Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) “Interest” is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably required to operate a program, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

*u. Rate formula.* Paragraph 150.3(5) “p” notwithstanding, when rates are determined based on cost of providing the service involved, they will be calculated according to the following mathematical formula:

$$\frac{\text{Net allowable expenditures}}{\text{Effective utilization level}} \times \text{Reimbursement factor} = \text{Base Rate}$$

(1) Net allowable expenditures are those expenditures attributable to service to clients which are allowable as set forth in subrule 150.3(5), paragraphs “a” to “t.”

(2) Effective utilization level shall be 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

(3) Inflation factor is the percentage which will be applied to develop payment rates consistent with current policy and funding of the department. The inflation factor is intended to overcome the time lag between the time period for which costs were reported and the time period during which the rates will be in effect. The inflation factor shall be the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31.

(4) Base rate is the rate which is developed independent of any limits which are in effect. Actual rates paid are subject to applicable limits or maximums.

*v.* Rescinded IAB 5/13/92, effective 4/16/92.

**150.3(6) Client eligibility and referral.**

*a.* Program eligibility. To receive services through the purchase of service system, clients shall be determined eligible and be formally referred by the department.

(1) The department shall not make payment for services provided before the client’s application, eligibility determination, and referral. See “b” below for an exception to this requirement.

(2) Except as provided in paragraph “c,” the department shall use the following forms to authorize services:

1. Form 470-0622, Referral of Client for Purchase of Social Services.
2. Form 470-0719, Placement Agreement: Child Placing or Child Caring Agency (Provider).

*b.* When a court orders foster care and the department has no responsibility for supervision or placement of the client, the department will pay the rate established by these rules for maintenance and service provided by the facility.

*c.* Family-centered services. For family-centered services, the provisions in rule 441—172.3(234) relating to approval, authorization, and referral shall apply.

**150.3(7) Client fees.** The provider shall agree not to require any fee for service from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy. Rules governing client fees are found in 441—130.4(234).

The provider shall collect fees due from clients. The provider shall maintain records of fees collected, and these records shall be available for audit by the department or its representative. When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. Reasonable effort to collect means an original billing and two follow-up notices of nonpayment. When the second notice of nonpayment is sent, the provider shall send a copy of the notice to the department worker.

**150.3(8) Billing procedures.** At the end of each month the provider agency shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided by the agency during the month.

Separate invoices shall be prepared for each county from which clients were referred, each service, and each funding source involved in payment. Complete invoices shall be sent to the departmental county office responsible for the client for approval and forwarding for payment.

More frequent billings may be permitted on an exception basis with the written approval of the service area and the chief of the bureau of purchased services.

*a.* Time limit for submitting vouchers, invoices, or claims. The time limit for submission of original vouchers, invoices, or claims shall be three months from the date of service.

*b.* Resubmittals of rejected claims. Valid claims which were originally submitted within the time limit specified in paragraph “a” but were rejected because of an error shall be resubmitted without regard to time frames.

**150.3(9) Reviews of departmental actions.** A provider who is adversely affected by a departmental decision may request a review. A review request may cause the action to be stopped pending the outcome of the review, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

*a.* The provider shall send a written request for review to the project manager responsible for the contract within ten days of receipt of the decision in question. This request shall document the specific area in question and the remedy desired. The project manager shall provide a written response within ten days.

*b.* When dissatisfied with the response, the provider shall submit to the service area manager within ten days the original request, the response received, and any additional information desired. The service area manager shall study the concerns and the action taken, and render a decision in writing within 14 days. A meeting with the provider may be held to clarify the situation.

*c.* If still dissatisfied, the provider may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs “a” and “b” above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting may be held with the provider, project manager, and service area manager or designee.

*d.* The provider may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

**150.3(10) Review of financial and statistical reports.** Authorized representatives of the department or state or federal audit personnel shall have the right to review the general financial records of a provider. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.3(5). Representatives shall provide proper identification and shall use generally

accepted auditing principles. The reviews may include an on-site visit to the provider, the provider's central accounting office, the offices of the provider's agents, a combination of these, or, by mutual decision, to other locations.

**150.3(11)** Rescinded, effective 3/1/87.

This rule is intended to implement Iowa Code section 234.6.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8447B**, IAB 1/13/10, effective 1/1/10; **ARC 8651B**, IAB 4/7/10, effective 5/12/10; **ARC 8902B**, IAB 6/30/10, effective 7/1/10; **ARC 0860C**, IAB 7/24/13, effective 7/1/13; **ARC 1060C**, IAB 10/2/13, effective 11/6/13; **ARC 2342C**, IAB 1/6/16, effective 2/10/16]

**441—150.4(234) Iowa purchase of social services contract—individual providers.**

**150.4(1)** *Individual child day care provider agreement.* Rules governing individual child day care provider agreements may be found in 441—Chapter 170.

**150.4(2)** *Individual in-home health-related provider agreement.* Rules governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

**441—150.5(234) Iowa purchase of administrative support.**

**150.5(1)** *Initiation of contract proposal.*

*a. Right to request a contract.* All potential contractors have a right to request a contract.

*b. Initial contact.*

(1) Volunteer contract. The initial contact for a volunteer contract may be between the potential contractor and the service area manager of the service area in which the individual or the contractor agency's headquarters is located or the contract may be between the potential contractor and the director of the state volunteer program in the central office of the department. If so, the director will communicate with the service area.

(2) General use administrative support contract. The initial contact for a general use administrative support contract may be between the potential contractor and the service area manager of the service area in which the individual or contractor organization's headquarters is located or the contract may be between the potential contractor and the chief of the bureau of purchased services, who will communicate with the service area.

*c. Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This includes documentation that the conditions of participation required below are met.

*d. Contract proposal approval or rejection.* Before a contract can be effective it shall be signed by the following persons within the time frames provided:

(1) Volunteer contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Director of the state volunteer program within 30 days from receipt.

(2) General use administrative support contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Chief of the bureau of purchased services within two weeks from receipt.

Administrator of the division of fiscal management within two weeks from receipt.

The contractor shall be notified of delays in the process or of rejection of the proposal. This notification along with an explanation shall be in writing. The applicant has a right to have the decision reviewed by the director of the state volunteer program, or chief of the bureau of purchased services.

*e. Criteria for rejection.* The following criteria may cause a proposed contract to be rejected.

(1) The proposed activity is not needed by the department.

(2) No funds are available for the activity being proposed.

(3) The proposed contract does not meet applicable rules, regulations, or guidelines.

*f. Contract effective date.* If the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the director of the state volunteer program, or the chief of the bureau of purchased services.

**150.5(2) Contract administration.**

*a. Contract management.* During the contract period, the assigned project manager shall be the liaison between the department and the contractor. The project manager shall be contacted on all interpretations and problems related to the contract and shall follow issues through to their resolution. The project manager shall also monitor performance under the contract and will provide or arrange for technical assistance to improve the contractor's performance, if needed.

*b. Contract amendments.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of providing the volunteer services must include reestablishment of amounts to be paid.

*c. Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days prior to the expiration date. Each contract shall be evaluated. The results of the evaluation shall be taken into consideration in the decision on renewal. This evaluation may involve use of evaluation tools specified in the contract.

*d. Contract termination.* Causes for termination during the period of the contract are:

- (1) Mutual agreement of the parties involved.
- (2) Demonstration that sufficient funds are unavailable to continue the service(s) involved.
- (3) Failure to make reports required by the contract.
- (4) Failure to make financial, statistical, and program records available.
- (5) Failure to abide by the provisions of the contract.

**150.5(3) Conditions of participation.** The contractor shall meet the following standards:

*a. Licensure, approval, or accreditation.* The contractor shall have any license, approval, and third-party accreditation required by law, regulation, or administrative rules, or shall meet standards of operation required by state or federal regulation. This requirement must be met before the contract can be effective.

*b. Signed contract.* A contract can be effective only when signed by all parties required in 150.5(1) "d."

*c. Civil rights laws.* The contractors shall be in compliance with all federal, state, and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance.

*d. Title VI compliance.* The contractors shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance.

*e. Section 504 compliance.* The contractors shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance.

*f. Affirmative action.* The contractors shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance.

*g. Abuse reporting.* The contractor shall have an approved policy and procedure for reporting abuse or denial of critical care of children or dependent adults.

*h. Confidentiality.* The contractor shall comply with all applicable federal and state laws and regulations on confidentiality.

*i. Financial and statistical records.* Each contractor of service shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, or state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

*j. Certification by department of transportation.* Each contractor who supplies transportation services shall submit Form 020107, Certification Application for Coordination of Public Transit Services, and a copy of “Certificate of Insurance” (an ACORD form or similar or self-insurance documentation) to the applicable project manager annually showing information regarding compliance with, or exemption from, public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910.

Failure to provide the required documentation for compliance or exemption is grounds for denial or termination of the contract.

**150.5(4) *Establishing amounts to be paid.*** The amounts to be paid under purchase of administrative support contracts are actual approved expenses as negotiated in the contract. Approved items of cost are based on submission of a proposed budget listing those items necessary for provision of the volunteer coordination or technical assistance to be delivered. At the termination of the contract a statement of actual expenses incurred shall be submitted by the contractor.

**150.5(5) *Billing procedures.*** At the end of each month, or as otherwise provided in the contract, the contractor shall prepare a claim on Form GAX, General Accounting Expenditure, for expenses for which reimbursement is permitted in the contract. The claim shall be sent to the office of the department that administers the contract for approval and forwarding for payment.

*a. Time limit for submitting claims.* The time limit for submission of original claims shall be within 90 days of the provision of service.

*b. Resubmittals of rejected claims.* Valid claims which were originally submitted within this time limit but were rejected because of an error must be resubmitted, but without regard to time frames.

**150.5(6) *Reviews of department actions.*** A contractor who is adversely affected by a department decision may request a review. A review request may cause the action to be stopped pending the outcome of the review process, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

*a.* Within ten days of receipt of the decision in question the contractor shall send a written request for review to the project manager responsible for the contract. This request shall document the specific area in question and the remedy desired. A written response from the project manager shall be provided within ten days.

*b.* When dissatisfied with the response, the contractor shall submit the original request, the response received, and any additional information desired to the service area manager within ten days. The service area manager shall study the concerns, the action taken and render a decision in writing within 14 days. A meeting with the contractor may be held to clarify the situation.

*c.* If still dissatisfied, the contractor may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs “a” and “b” above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting with the contractor, project manager, and service area manager or designee may be held.

*d.* The contractor may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

**150.5(7) *Reviews.*** Authorized representatives of the department or state or federal audit personnel have the right to review the general financial records of a contractor. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.5(4). Representatives shall provide proper identification and shall use generally accepted auditing principles. The reviews may be on the basis of an on-site visit to the contractor, the contractor’s central accounting office, the offices of the contractor’s agents, a combination of these, or, by mutual decision, to other locations.

This rule is intended to implement Iowa Code sections 234.6 and 324A.5, subsection 3, paragraph “c.”

**441—150.6(234) County board of supervisors participation contract.** Rescinded IAB 7/8/92, effective 7/1/92.

**441—150.7(234) Iowa donation of funds contract.** Rescinded IAB 12/3/08, effective 2/1/09.

**441—150.8(234) Provider advisory committee.** Rescinded IAB 12/3/08, effective 2/1/09.

**441—150.9(234) Public access to contracts.** Subject to applicable federal and state laws and regulations on confidentiality including 441—Chapter 9, all material submitted to the department of human services pursuant to this chapter shall be considered public information.

These rules are intended to implement Iowa Code section 234.6 and 2001 Iowa Acts, House File 732, section 31, subsection 6, and Senate File 537, section 1, subsection 1, paragraph “d.”

**441—150.10 to 150.20** Reserved.

- DIVISION II  
PURCHASE OF SOCIAL SERVICES CONTRACTING ON BEHALF OF COUNTIES FOR  
LOCAL PURCHASE SERVICES FOR ADULTS WITH MENTAL ILLNESS,  
MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES  
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CHAPTER 202  
FOSTER CARE PLACEMENT AND SERVICES

[Prior to 7/1/83, Social Services[770] Ch 136]  
[Previously appeared as Ch 136—renumbered IAB 2/29/84]  
[Prior to 2/11/87, Human Services[498]]

**441—202.1(234) Definitions.**

*“Age- or developmentally appropriate activities”* means activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

*“Case permanency plan”* shall mean the plan identifying goals, needs, strengths, problems, services, time frames for meeting goals and for delivery of the services to the child and parents, objectives, desired outcomes, and responsibilities of all parties involved and reviewing progress.

*“Child”* shall mean the same as defined by Iowa Code section 234.1.

*“Department”* shall mean the Iowa department of human services and includes the local offices of the department.

*“Eligible child”* shall mean a child for whom the court has given guardianship to the department or has transferred legal custody to the department or for whom the department has agreed to provide foster care services on the basis of a signed placement agreement or who has been placed in emergency care for a period of not more than 30 days upon the approval of the director or the director’s designee.

*“Facility”* means the personnel, program, plant and equipment of a person or agency providing child foster care.

*“Family safety, risk, and permanency service”* means a service provided under 441—Chapter 172 that uses strategies and interventions designed to achieve safety and permanency for a child with an open department child welfare case, regardless of the setting in which the child resides.

*“Foster care”* shall mean substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child’s parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision, and health care.

*“Natural parent”* shall mean a parent by blood, marriage, or adoption.

*“Person”* or *“agency”* shall mean individuals, institutions, partnerships, voluntary associations, and corporations, other than institutions under the management or control of the department, who are licensed by the department as a foster family home, child caring agency or child placing agency, or approved as a shelter care facility.

*“Reasonable and prudent parent standard”* means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encourage the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, and social activities. For the purposes of this definition, “caregiver” means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution (including group homes, residential treatment, shelters, or other congregate care settings) in which a child in foster care has been placed.

*“Resource family”* means an individual person or married couple who is licensed to provide foster family care or approved for adoption.

*“Safety-related information”* means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

“*Service area manager*” shall mean the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

“*Social history*” or “*child study*” means a written description of the child that includes strengths and needs; medical, mental, social, educational, placement and court history; and the child’s relationships with the birth family and significant others.

This rule is intended to implement Iowa Code section 234.6(6) “*b.*”  
[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 2069C, IAB 8/5/15, effective 10/1/15]

#### **441—202.2(234) Eligibility.**

**202.2(1)** Only an eligible child as defined in these rules shall be considered for foster care services supervised by the department.

**202.2(2)** The need for foster care placement and social and other related services, including but not limited to medical, psychiatric, psychological, and educational services, shall be determined by an assessment of the child and family to determine their needs and the appropriateness of services.

*a.* Assessments shall include:

(1) The educational, physical, psychological, social, family living, and recreational needs of the child,

(2) The family’s ability to meet those needs, and

(3) A family genogram to determine relatives and other suitable support persons who have a kinship bond with the child.

*b.* The assessment is a continual process to identify needed changes in service or placement for the child.

**202.2(3)** With the exception of emergency care, a social history shall be completed on each child before a department recommendation for foster care placement, using the outline RC-0027, Social History Format.

*a.* For voluntary emergency placements, a social history shall be completed before a decision is made to extend the placement beyond 30 days.

*b.* For court-ordered emergency placements, a social history shall be completed before the disposition hearing.

**202.2(4)** Foster care placement shall be recommended by the department only after efforts have been made to prevent or eliminate the need for removal of the child from the family unless the child is in immediate danger at home.

**202.2(5)** The need for foster care and the efforts to prevent placement shall be evaluated by a review committee prior to placement or, for emergency placements only, within 30 days after the date of placement. For children who are mentally retarded or developmentally disabled and receive case management services, this requirement may be met by the interdisciplinary staffing described in 441—Chapter 90, as long as the service area manager approves, the department worker attends the staffing, and the staffing meets the requirements of paragraphs “*b*” to “*h*” below.

The review shall meet the following requirements:

*a.* Department staff on the review committee shall be the child’s service worker, a supervisor knowledgeable in child welfare, and one or more additional persons appointed by the service area manager.

*b.* The review shall be open to the participation of the parents or guardian of the child, local and area education staff, juvenile court staff, the guardian ad litem, current service providers and previous service providers who have maintained a license.

*c.* The present foster care provider, if any, shall be notified of the review and have the opportunity to participate.

*d.* Written notice of the review shall be sent to the child’s parents or guardian at least five working days prior to the date of the review.

*e.* Other persons may be invited to the review with the consent of the parents or guardian.

*f.* A written summary of the review recommendations shall be sent to the child's parents or guardian following the review.

*g.* Review committee recommendations shall be advisory to the service worker and supervisor, who are responsible for development of the department case plan and for reports and recommendations to the juvenile court.

*h.* At least one of the persons on the review committee shall be someone without responsibility for the case management or the delivery of services to either the child or the parents or guardian who are the subject of the review.

**202.2(6)** The citizenship or alien status of a child who enters foster care must be verified.

*a.* When the child will remain in foster care for no more than 60 days, Form 470-4500, Statement of Citizenship Status: Foster Care, signed by the parent or guardian of the child is sufficient.

*b.* When the child will remain in foster care for more than 60 days, one of the documents listed in this paragraph is required. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A certificate of birth in the United States.

(2) Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

(3) Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

(4) A United States passport.

(5) Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

(6) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(7) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(8) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(9) Another document that provides proof of United States citizenship or nationality as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v) or 1396b(x)(3)(C)(v).

*c.* A child entering foster care is exempt from these requirements when the family has previously presented satisfactory documentary evidence of citizenship, as specified by the Secretary of the U.S. Department of Health and Human Services.

*d.* The parent or guardian of the child shall have a reasonable period to obtain and provide proof of citizenship. For the purposes of this requirement, the "reasonable period" begins on the date when the child is placed in foster care and continues to the date when the proof is provided or when the department establishes that the parent or guardian is no longer making a good-faith effort to obtain the proof.

This rule is intended to implement Iowa Code sections 234.6(1) and 234.6(6) "b."

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

#### **441—202.3(234) Voluntary placements.**

**202.3(1)** All voluntary placement agreements initiated after July 1, 2003, for children under the age of 18 shall terminate after 90 days.

**202.3(2)** When the voluntary placement is of a child who is under the age of 18, a Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the parent(s) or guardian and the county office where the parent or guardian resides. Voluntary Foster Care Placement Agreements shall not be used to place children outside Iowa and shall not be signed with parents or guardians who

reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's parent or guardian moves outside Iowa after the placement.

**202.3(3)** Voluntary placement of a child aged 18 or older may be granted for six months at a time.

*a.* The department shall enter into the agreement only when the child:

- (1) Meets the definition of "child" in Iowa Code section 234.1,
- (2) Was in foster care or a state institution immediately before reaching the age of 18,
- (3) Has continued in foster care or a state institution since reaching the age of 18,
- (4) Has demonstrated a willingness to participate in case planning and to fulfill responsibilities as defined in the case permanency plan, and
- (5) Will be placed in foster family care or supervised apartment living in Iowa.

*b.* Payment shall be limited pursuant to 441—paragraph 156.20(1) "b."

*c.* When the voluntary placement is of a child who is aged 18 or older and who has a court-ordered guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the guardian and the local office where the guardian resides. Voluntary Foster Care Agreements shall not be signed with guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's guardian moves outside Iowa after the placement.

*d.* When the voluntary placement is of a child who is aged 18 or older and who does not have a court-appointed guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the child and the local office where the child resides.

*e.* An exception to the requirement for continuous placement may be made for a youth who leaves foster care at age 18 and voluntarily returns to supervised apartment living foster care before the youth's twentieth birthday in order to complete high school or obtain a general equivalency diploma (GED).

**202.3(4)** All voluntary placements shall be approved by the service area manager or designee.

This rule is intended to implement Iowa Code sections 234.6(6) "b" and 234.35(1) "c."

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—202.4(234) Selection of facility.**

**202.4(1)** Placement consistent with the best interests and special needs of the child shall be made in the least restrictive, most family-like facility available and in close proximity to the child's home. Race, color, or national origin may not be routinely considered in placement selections.

**202.4(2)** Efforts shall be made to place siblings together unless to do so would be detrimental to any of the children's physical, emotional or mental well-being. Efforts to prevent separating siblings, reasons for separating siblings, and plans to maintain sibling contact shall be documented in the child's case permanency plan.

**202.4(3)** The department shall first consider placing the child in a relative's home unless no relatives are available or willing to accept placement or such placement would be detrimental to the child's physical, emotional or mental well-being.

*a.* If a relative or a suitable person who has a kinship bond with the child will accept placement of the child:

- (1) The person shall sign Form 595-1489, Non-Law Enforcement Record Check Request, and
- (2) The department shall complete record checks as listed in 441—subrule 113.13(1) to evaluate if the person's home is appropriate for the child before making the placement.

*b.* Efforts to place the child in a relative's home and reasons for using a nonrelative placement shall be documented in the child's case permanency plan.

**202.4(4)** If the child cannot be placed with a relative or a suitable person who has a kinship bond with the child, foster family care shall be used for a child unless the child has problems which require specialized services that cannot be provided in a family setting. Reasons for using a more restrictive placement shall be documented in the child's case permanency plan.

**202.4(5)** A foster family shall be selected on the basis of compatibility with the child, taking into consideration:

*a.* The extent to which interests, strengths, abilities and needs of the foster family enable the foster family members to understand, accept and provide for the individual needs of the child.

*b.* The child's individual problems, medical needs, and plans for future care. The department shall not place a child with asthma or other respiratory health issues in a foster home where any member of the household smokes.

*c.* The capacity of the foster family to understand and accept the child's case permanency plan, the needs and attitudes of the child's parents, and the relationship of the child to the parents.

*d.* The characteristics of the foster family that offer a positive experience for the child who has specific problems as a consequence of past relationships.

*e.* An environment that will cause minimum disruption of the child including few changes in placement for the child.

*f.* Rescinded IAB 4/11/07, effective 7/1/07.

**202.4(6)** A foster group care facility shall be selected on the basis of its ability to meet the needs of the child, promote the child's growth and development, and ensure physical, intellectual and emotional progress during the stay in the facility. The department shall place a child only in a licensed or approved facility which has a current contract with the department pursuant to 441—Chapter 152.

This rule is intended to implement Iowa Code section 234.6(6) "b."  
[ARC 8010B, IAB 7/29/09, effective 10/1/09]

#### **441—202.5(234) Preplacement.**

**202.5(1)** Except for placements made in less than 24 hours, a child placed in a facility shall have a preplacement visit involving:

- a.* The child,
- b.* The foster parents or agency staff, if the child is placed in a public or private agency,
- c.* The department service worker, and
- d.* The child's parents, unless their presence would be disruptive to the child's placement.

**202.5(2)** Before placement, the worker shall provide the facility with general information regarding the child, including a description of the child's medical needs, behavioral patterns including safety-related information, educational plans, and permanency goal. Safety-related information shall be withheld only if:

- a.* Withholding the information is ordered by the court; or
- b.* The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

**202.5(3)** The child shall have a physical examination by a physician before the initial placement in foster care or within 14 calendar days of placement. The physician shall complete a preliminary screening for dental and mental health and refer the child to a dentist or mental health professional if appropriate. To address any immediate medical needs, the child shall be seen immediately at an emergency room, an urgent care center, or other community health resource.

This rule is intended to implement Iowa Code section 234.6(6) "b."  
[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09]

#### **441—202.6(234) Placement.**

**202.6(1)** At the time of placement, the department worker shall furnish to the foster care provider any available information regarding the child.

- a.* The information provided shall include:
  - (1) The child's full name and date of birth;
  - (2) The names, work addresses, and telephone numbers of the placement worker and the worker's supervisor, including a home telephone, cell phone, or on-call number;
  - (3) The names, addresses, and telephone numbers of the child's physician and dentist;
  - (4) The names, addresses, and telephone numbers of significant relatives of the child, including parents, grandparents, brothers and sisters, aunts and uncles, and any other significant persons (for an adopted child, the adoptive parents and adoptive relatives);
  - (5) The case permanency plan;
  - (6) The results of a physical examination, including immunization history;

- (7) The child's medical needs including allergies, physical limitations, dental and medical recommendations, and special needs of HIV;
- (8) Behavioral patterns including safety-related information;
- (9) Educational arrangements including, but not limited to, the school the child attends, special education needs, and school contacts;
- (10) The placement contract or agreement including the date of acceptance for care;
- (11) Medical authorizations, service authorizations, and other releases as needed; and
- (12) If the child is an Indian, the identification of the child's tribe and tribal social service agency including telephone number and contact person.

*b.* Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information.

(1) The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

(2) Form 470-3226, HIV General Agreement, shall be completed by foster parents who have agreed to care for children who have AIDS, test HIV positive, or are at risk for HIV infection.

*c.* Safety-related information shall be withheld only if:

- (1) Withholding the information is ordered by the court; or
- (2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

**202.6(2)** For each foster care placement in a foster family home supervised directly by department staff, Form 470-0716 or 470-0716(S), Foster Family Placement Contract, shall be completed by the foster family and the placement worker and supervisor. A new foster family placement contract shall be completed when the rate of payment or special provisions change.

**202.6(3)** A follow-up visit shall be made to the child at the foster family home within two weeks of the initial placement for placements supervised directly by the department.

**202.6(4)** The case permanency plan shall be reviewed at least every six months to ensure appropriateness of the child's placement. A copy of the subsequent case plan shall be submitted to the court every six months unless the court orders a different frequency for reports.

**202.6(5)** In conjunction with the case plan review, the case shall be presented every six months to a review committee which conforms to the requirements in subrule 202.2(5). The service area manager may also approve a review by a local foster care review board authorized in Iowa Code section 237.19 or the court as meeting this requirement as long as the review conforms to subrule 202.2(5), paragraphs "b" to "h," and to subrule 202.6(5), paragraphs "a" to "e." The review committee shall:

- a.* Evaluate the continuing necessity for foster care placement.
- b.* Evaluate the continuing appropriateness of the foster care placement.
- c.* Evaluate the extent of compliance with the case plan.
- d.* Evaluate the extent of progress made toward lessening the causes for foster care placement.
- e.* Project a likely date by which the child will leave foster care.

This rule is intended to implement Iowa Code sections 234.6(6) "b," and 237.19.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

#### **441—202.7(234) Out-of-area placements.**

**202.7(1)** When the department makes a placement of a child in the foster care system out of the service area in which the child resides, this placement shall occur only when there is no appropriate placement within the service area, when the placement is necessary to facilitate reunification of the child with the parents, or when an out-of-area agency is closer to the community where the child resides than an in-area agency offering the same services.

**202.7(2)** The authority for approving out-of-area placements rests with both the placing and receiving service area managers.

**202.7(3)** Transfer of responsibility for supervision, planning, and visitation shall be approved by the placing and receiving service area managers and, when appropriate, by the court.

This rule is intended to implement Iowa Code section 234.6(6)“b.”

**441—202.8(234) Out-of-state placements.**

**202.8(1)** The department shall make an out-of-state foster family care placement only with the approval of the service area manager or designee. Approval shall be granted only when the placement will not interfere with the goals of the child’s case permanency plan and when one of the following conditions exists:

- a. The foster family with whom the child is placed is moving out of state.
- b. An out-of-state family having previous knowledge of the child desires to provide foster care to the child.
- c. An out-of-state family is approved to adopt the child under subsidy and is eligible to receive maintenance payments until the adoption is final.
- d. An out-of-state placement is necessary to facilitate reunification of the child with the parents.

**202.8(2)** Placements shall be made in an out-of-state group care facility only with the approval of the service area manager or designee.

**202.8(3)** All out-of-state placements shall be made pursuant to interstate compact procedures.

**202.8(4)** The reasons for selecting an out-of-state placement shall be documented in the child’s case permanency plan.

**202.8(5)** Regional out-of-state placement committees. Rescinded IAB 7/6/94, effective 7/1/94.

This rule is intended to implement Iowa Code section 234.6(6)“b.”

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—202.9(234) Supervised apartment living.** A supervised apartment living arrangement shall provide a child with an environment in which the child can experience living in the community with supervision and prepare for self-sufficiency. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting and must be able to follow the provisions of the case plan and participate in activities and services to achieve self-sufficiency.

**202.9(1) Living arrangements.**

a. The two types of supervised apartment living arrangements are as follows:

(1) A cluster setting, which provides support in a structured setting. Up to six children reside in apartments or bedrooms in one building (such as an apartment building or residential housing), supervised by one agency. The supervising agency must have an adult staff member present and available on site in the living arrangement at any time when more than one child is present.

(2) A scattered-site setting, which is the less restrictive of the two types of living arrangements. Up to three children supervised by one agency may reside in individual housing arrangements, such as apartments or residential housing, located in one building. Children must be able to contact supervising agency staff 24 hours a day, seven days a week.

b. If an agency rents an apartment to the child, there shall be a signed lease between both parties that includes, but is not limited to:

- (1) Amount to be paid for the rental unit.
- (2) The term of the lease with both a beginning and an ending date.
- (3) Rights and responsibilities of the tenant.
- (4) Rights and responsibilities of the landlord.
- (5) Conditions under which the lease can be terminated.

**202.9(2) Eligibility.** To be eligible for supervised apartment living placement, a child shall meet all of the following conditions:

- a. The child must be at least 16½ years old for placement in a cluster setting.
- b. The child must be at least 17 years old for placement in a scattered-site setting.
- c. If the child is under the age of 18, the child must:

(1) Satisfactorily attend school, in accordance with the school's attendance policies, with the objective of obtaining a high school diploma; or

(2) Satisfactorily attend an instructional program, pursuant to the program's policies, necessary to obtain a general equivalency diploma (GED); or

(3) Attend school to obtain postsecondary education or training on a full-time basis (based upon the institution's definition of full-time) or attend on a part-time basis and be either working or participating in a work training program leading to employment; or

(4) Work at least an average of 80 hours per month if not enrolled in school; or

(5) Participate in a work training program leading to employment if not enrolled in school.

d. If the child is aged 18 or older, the child must:

(1) Meet the definition of "child" in Iowa Code section 234.1; and

(2) Have been in foster care immediately before reaching the age of 18 and have continued in foster care since reaching the age of 18. The service area manager or designee may waive the requirement for continuous placement for a child who leaves foster care at age 18 and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a GED, consistent with Iowa Code sections 234.35(1) "f" and 234.35(3) "c"; and

(3) Attend school on a full-time basis leading to a high school diploma or attend an instructional program leading to a GED.

e. The child must need foster care placement and services, based on an assessment completed according to rule 441—202.2(234) and subrule 202.6(5).

f. The child must participate in services and activities to achieve self-sufficiency.

g. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting, as determined by an assessment that reviews available information on the child to identify the needs, strengths, and resources of the child, especially as they pertain to the child's ability to function in the community. To determine if a supervised apartment living foster care placement is suitable for the child, the department worker must complete Form 470-4063, Preplacement Screening for Supervised Apartment Living Foster Care.

h. The child must have an approved living situation that meets the following minimum standards:

(1) Comply with applicable state and local zoning, fire, sanitary and safety regulations.

(2) Be located so as to provide reasonably convenient access to schools, places of employment, and services and supports required by the child.

(3) Be reasonably priced so as to fit within the child's budget.

i. If supervised apartment living foster care is deemed suitable for the child, the worker shall complete Form 470-3186, Request for Approval of Supervised Apartment Living Foster Care Placement, to request that the service area manager or designee approve the placement. This form is also to be used to request that the service area manager or designee waive the requirement for continuous placement for a child who leaves foster care on or after the child's eighteenth birthday and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a GED.

j. The placement must have the approval of the juvenile court if the child is under court jurisdiction.

**202.9(3) Services to be provided.** To ensure that the supervised apartment living arrangement is meeting the child's needs, required services shall be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. The following services are required:

a. Development of a case or service plan (by either the department worker or the service provider, if contracted out) in consultation with the child and the child's family (unless a reason for noninvolvement is documented in the case record) and significant others whenever appropriate that documents the following:

(1) Goals, intended to meet the specific needs of the child to achieve self-sufficiency, with projected dates of accomplishment.

(2) Objectives (action steps) to be taken by the child, the child's support system, and staff, with projected dates of accomplishment.

(3) Services to be provided and activities to be undertaken, the frequency of such services, who will provide the services, the child's progress with the goals and objectives, and the child's compliance with the service plan.

(4) A budget, developed with the child, based upon the child's monthly maintenance payment, any start-up allowance, any earned or unearned incomes and financially related assistance (e.g., food assistance). Staff will work with the child to ensure payment of bills and receipt of necessary items as outlined in the budget.

b. Life skills training involving interpersonal and daily living skills training to prepare the child to maintain a safe, healthy, and stable lifestyle and achieve self-sufficiency. Life skills training includes training of "hard" skills (e.g., money management, self-care and hygiene, physical and mental health care, skills related to educational and employment goals, housing and home management, time management, accessing community resources) and training of "soft" skills (e.g., decision making, problem solving, developing healthy relationships, self-advocacy). Life skills training should be individualized to the needs of the child toward achieving self-sufficiency. If a child needs a specific life skills training service or services (e.g., parenting skill development, counseling services to reduce stress and social, emotional, or behavioral problems that affect the child's stability or ability to achieve self-sufficiency) in addition to basic life skills training services and services are purchased, the department worker will specify the necessary services under special provisions on Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL).

c. Through visits with the child and to the living situation, determination and documentation that:

(1) The living arrangement and mode of living are safe and suitable and provide an environment that allows for the child's social and emotional needs to be met; and

(2) There is no reasonable cause to believe that the child's living situation or mode of living presents any unacceptable risks to the child's health or safety; and

(3) The child has access to a telephone; and

(4) There is an operating smoke alarm on each level of occupancy; and

(5) The child is receiving any necessary medical care; and

(6) The child is receiving appropriate and sufficient services and supports to achieve the child's goals and facilitate objectives according to the child's service plan.

d. Supervision to assist the child in developing the needed structure to live in the supervised apartment living setting and in locating and using other needed services. If the child is under the age of 18, supervision shall include a minimum of weekly face-to-face contacts. For a child aged 18 or older, supervision shall include a minimum of biweekly (every other week) face-to-face contacts. Supervision may include guidance, oversight, and behavior monitoring.

e. Ongoing assessment activities to monitor the child's ability to achieve self-sufficiency.

f. If services are purchased, visits by the department to the child according to subrule 202.11(2).

g. If services are purchased, compliance by the provider with all reporting requirements in 441—paragraph 150.3(3)"j," including requirements for the individual service plan, quarterly reports, and a termination summary.

h. A review of the case and case plan every six months, in accordance with subrules 202.6(4) and 202.6(5).

**202.9(4) Method of service provision.** Supervised apartment living services may be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. If services are purchased:

a. Department staff shall be responsible to determine the specific service components and the specific number of service units to be provided for required services. The department case permanency plan shall specify the goals and objectives (action steps) of the services that are being purchased. If services are purchased, the worker shall complete Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL), to place the child with the contractor and to authorize service codes (scattered-site or cluster setting; individual services or services provided with a group of children in supervised apartment living placement) and the specific number of units to be provided and billable.

*b.* Service billings for services shall be based on one hour (one unit equals one hour of service), or any portion thereof (with monthly cumulative units rounded up or down to the nearest whole unit), of:

(1) Direct face-to-face contact between the service provider and the child.

(2) Activities undertaken to assist the child in developing the needed structure and supports to live in the supervised apartment living setting.

(3) Activities undertaken to assist the child in locating and using other needed services, supports, and community resources and to consult and collaborate on service directions on behalf of the child with schools, employers, landlords, volunteers, extended family members, peer support groups, training resources, or other community resources.

*c.* Service billings for group services shall be based on one hour (one unit equals one hour of service), or any portion thereof (with monthly cumulative units rounded up or down to the nearest whole unit), for each child in the group.

*d.* Expenses of transporting the child, service management activities, and other administrative functions shall be allowable indirect costs subject to the restrictions set forth in rule 441—150.3(234) and are not billable units of service.

*e.* Contractors providing a cluster setting shall be paid \$551.25 per month per child in the setting for agency staffing costs, in addition to billable units of services provided to the child, but are eligible for this payment only when two or more children are in the setting. For a child who enters a cluster setting during the month, the prorated amount per day is \$18.12. If a child exits the setting on or before the last day of the month, the \$551.25 shall be prorated up to the date before the date of exit.

**202.9(5) Termination of services.**

*a.* Mandatory termination. Supervised apartment living services shall be terminated when the child:

(1) No longer meets eligibility criteria;

(2) No longer needs services or needs a more restrictive level of placement;

(3) Chooses to live in a nonapproved setting; or

(4) Refuses to follow the provisions of the case plan.

*b.* When services are purchased and the department plans to remove a child from the supervised apartment living placement, the department shall inform the provider in writing of the date of removal, the reason for the removal, the recourse available, if any, and that the contested case (appeal) proceeding does not apply to the removal.

*c.* The provider shall be informed ten days in advance of the removal, except when the court orders removal of the child from the placement or there is evidence of neglect or physical or sexual abuse.

This rule is intended to implement Iowa Code section 234.6.

[ARC 0417C, IAB 10/31/12, effective 1/1/13; ARC 2342C, IAB 1/6/16, effective 2/10/16]

**441—202.10(234) Services to foster parents.** Foster parents shall be provided necessary supportive services for the purpose of aiding them in the care and supervision of the child. These services shall include, but not be limited to:

**202.10(1)** Availability of social service staff on a 24-hour basis in case of emergency.

**202.10(2)** Conferences to develop in-depth planning regarding family visits, expectations of the department, future objectives and time frames, use of resources, and termination of placements.

**202.10(3)** Visitation by the service worker at least monthly regardless of the duration of the placements.

**202.10(4)** Making available all known pertinent information needed for the care of the child including HIV status, safety-related information, and special confidentiality requirements.

*a.* Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information. The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

*b.* Safety-related information shall be withheld only if:

- (1) Withholding the information is ordered by the court; or
- (2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. When continued breastfeeding of the child is determined to be in the best interest of the child, the service worker and the foster parents shall make reasonable efforts to support the continued breastfeeding of the child by the mother.

This rule is intended to implement Iowa Code section 234.6(6) “b.”

**441—202.11(234) Services to the child.** The department service worker shall maintain a continuous relationship with the child.

**202.11(1)** The department service worker shall:

- a. Help the child plan for the future,
- b. Evaluate the child’s needs and progress,
- c. Supervise the living arrangement,
- d. Arrange for social and other related services including, but not limited to, medical, psychiatric, psychological, and educational services from other resources as needed, and
- e. Counsel the child in adjusting to the placement.

**202.11(2)** The assigned department service worker shall personally visit each child in out-of-home care at least once every calendar month, with the frequency of the visits based upon the needs of the child.

- a. The visit shall take place in the child’s place of residence the majority of the time.
- b. The visit shall be of sufficient length to focus on issues pertinent to case planning. During the visit, the worker shall address the safety, permanency, and well-being of the child, including the child’s needs, services to the child, and achievement of the case permanency plan goals.

**202.11(3)** When placement of a breastfeeding child is made, the service worker shall:

- a. Assess in consultation with the worker’s supervisor whether continued breastfeeding by the mother is in the best interest of the child;
- b. Make every reasonable effort to support the mother’s continued breastfeeding for the child if determined appropriate; and
- c. Document the assessment and efforts in the child’s case plan and case notes.

**202.11(4)** When a child is in continuous foster care, a new physical examination shall not be required when the child transfers from one foster care placement to another unless there is some indication that an examination is necessary. The service worker shall obtain from the health practitioner or practitioners an annual medical review of treatment the child has received.

This rule is intended to implement Iowa Code section 234.6(6) “b.”

**202.11(5)** Throughout the provision of care, the foster care provider shall actively ensure that the child stays connected to the child’s kin, culture, and community as documented in the child’s case permanency plan.

**202.11(6)** Throughout the provision of care, the foster care provider is permitted to use the reasonable and prudent parent standard to create opportunities for participation of the child in age- or developmentally appropriate activities.

**202.11(7)** Transition planning program. The purpose of the transition planning program is to provide services, supports, activities and referrals to programs that assist children currently or formerly in foster care in acquiring skills and abilities necessary for transition to successful adulthood. The transition planning program offers a life skills assessment, transition plan development, and transition-related services, supports, activities and referrals to programs.

a. *Eligibility.* To be eligible for the transition planning program, a child must be or have been in foster care as defined by rule 441—202.1(234) or 45 Code of Federal Regulations 1355.20 as amended to October 1, 2008, and must meet at least one of the following eligibility requirements:

- (1) Is currently in foster care and is 14 years of age or older.
- (2) Is under the age of 21 and was adopted from foster care at 16 years of age or older.
- (3) Is under the age of 21 and was placed in a subsidized guardianship arrangement from foster care at 16 years of age or older.

(4) Was formerly in foster care and is eligible for and participating in Iowa's aftercare services program as described at 441—Chapter 187.

(5) Was formerly in foster care and is eligible for and participating in Iowa's postsecondary education and training voucher (ETV) program as described at 42 U.S.C. Section 677(a)(6-7).

*b. Assessment.* A life skills assessment shall be administered to all children in foster care who are aged 14 or older. An assessment shall be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph "a." The assessment is designed to evaluate the child's strengths and needs in areas including, but not limited to:

- (1) Education,
- (2) Physical and mental health,
- (3) Employment,
- (4) Housing and money management, and
- (5) Supportive relationships.

*c. Transition plan development.* A transition plan shall be completed for all children in foster care who are aged 14 or older, as provided in Iowa Code section 232.2(4) "f." Transition plan development shall also be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph "a," but the transition plan will not be part of a case permanency plan. Transition plan requirements include the following:

(1) The transition plan shall be personalized at the direction of the child and shall be developed in consultation with the child and reviewed by the department in collaboration with a child-centered transition team, honoring the goals and concerns of the child.

(2) The transition plan shall document that the child received and signed a document that describes the rights of the child with respect to education, health, visitation, and court participation. The document must be signed by the child indicating that the child has been provided with a copy of the document and that the rights contained in the document have been explained to the child in an age-appropriate way.

(3) The transition plan shall document that the child received a copy of any credit report pertaining to the child as provided by the child's caseworker on an annual basis until the child is discharged from foster care. The child must receive assistance from the child's caseworker in interpreting and resolving any inaccuracies in the report.

(4) The transition plan shall document that any child leaving foster care at the age of 18 or older was provided with the following documents and information unless the child has been in foster care for less than six months or is not eligible to receive such document:

1. An official or certified copy of the child's birth certificate.
2. The child's social security card.
3. A driver's license or identification card issued by the state to the child.
4. Health insurance information.
5. A copy of the child's medical and education records.

(5) The transition plan shall document that the caseworker provided to the child, at the case permanency plan review in the 90 days before the child reached the age of 18, information and education about the importance of having a durable power of attorney for health care and a copy of the state's form used to identify such a proxy. The child has the option to complete the form at the age of 18 or older.

(6) The transition plan shall address the strengths and needs identified in the assessment and detail the services, supports, activities and referrals to programs needed to implement the plan to best assist the child in preparing for successful adulthood. The membership of the transition team and the meeting dates for the team shall be documented in the transition plan.

(7) The transition plan shall be reviewed and updated at each case review after the plan's initial development; within 90 days before the child's eighteenth birthday; and within 90 days before the child is expected to leave foster care if the child remains in care after reaching the age of 18.

*d. Transition services.* Children shall be offered services, supports, activities and referrals to programs within, but not limited to, the five areas described below according to the child's age and development, strengths and needs, permanency goal, and placement as documented in the case permanency plan.

(1) Education skills increase the child's chances of completing high school or obtaining high school equivalency and of entering a satisfying career. Services may include assistance in academic advising and guidance, secondary and postsecondary educational support, records transfer coordination, tutoring, financial aid planning, career exploration, mentoring, and career advising. Financial assistance for postsecondary education and training may be available to eligible children.

(2) Physical and mental health skills promote healthy physical, mental and emotional functioning. Health education services may include guidance on risk prevention, how to be healthy and fit, how to self-advocate for health care needs and access to health insurance, how to select medical professionals, and how to make informed decisions regarding treatment, lifestyle considerations, spirituality, and recreation. Provision must be made for the child's application for adult services if it is likely the child will need or be eligible for services or other support from the adult service system.

(3) Employment skills enable children to prepare for, seek, and maintain gainful career employment. Services may include employment programs or vocational training, employment search resources, career advising, résumé writing, interview skills, workplace etiquette, and on-the-job training.

(4) Housing and money management skills prepare a child to select, manage, and maintain safe and stable housing. Services may include lessons on the physical maintenance and cleaning of a house and guidance on managing personal finances, such as financial decisions, budgeting, bill paying, use of credit, and financing. Financial assistance for items, including room and board, may be available to children who meet the eligibility criteria of the aftercare services program pursuant to 441—Chapter 187.

(5) Supportive relationships skills promote the healthy development and maintenance of rewarding, lasting relationships. Services may include family support and healthy marriage education, mentoring opportunities, and guidance on how to recognize the needs of others, how to identify and understand personal motivations, how to ensure personal safety, and how to communicate effectively.

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 8718B, IAB 5/5/10, effective 7/1/10; ARC 0417C, IAB 10/31/12, effective 1/1/13; ARC 2069C, IAB 8/5/15, effective 10/1/15]

#### **441—202.12(234) Services to parents.**

**202.12(1)** Child welfare services shall be made available to the parents throughout the period of placement for the purpose of reuniting the family in an agreed-upon time frame. Family safety, risk, and permanency services may be provided to:

- a. Promote identification and enhancement of family strengths and protective capacities;
- b. Address the factors that resulted in the child's being removed from the family home; and
- c. Strengthen family connections to community resources and informal supports.

**202.12(2)** Placement notification.

a. The parents shall be notified of the location and nature of the child's placement, unless the conditions of this subrule are met.

(1) The department evaluates the situation and determines that notifying the child's parents of the location of the placement would be detrimental to the child's safety and well-being and to the stability of the child's placement due to:

1. Evidence of a direct or indirect threat to harm the foster child or the foster family; or
2. Credible third-party information of a threat of harm to the foster child or the foster family.

(2) The department includes a statement in the child's case permanency plan explaining the decision not to disclose the location of the child to the parents.

b. The decision not to disclose the location of a child's placement shall be reviewed at least every six months when the child's case permanency plan is revised.

**202.12(3)** The case plan and treatment plan shall specify the services to be provided and the time frame for reuniting the family. These plans shall be developed in cooperation with the parents.

**202.12(4)** Personal contact shall be made regularly with the parents and the progress towards goal attainment reviewed and documented in the case record. The frequency of the personal contact shall be at least monthly and shall be specified in the child's case permanency plan.

**202.12(5)** When placement of a breastfeeding child is made, the service worker shall:

- a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;
- b. Make every reasonable effort to support the mother's continued breastfeeding of the child if determined appropriate; and
- c. Document the assessment and efforts in the child's case plan and case notes.

This rule is intended to implement Iowa Code section 234.6(6) "b."  
[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 9961B, IAB 1/11/12, effective 12/15/11]

**441—202.13(234) Removal of the child.**

**202.13(1)** When the department plans to remove a child from a facility, the facility shall be informed in writing of the date of the removal, the reason for the removal, the recourse available to the facility, if any, and that the chapter 17A contested case proceeding is not applicable to the removal. The department shall inform the facility ten days in advance of the removal, except that the facility may be informed less than ten days prior to the removal in the following instances:

- a. When the parent or guardian removes the child from voluntary placement.
- b. When the court orders removal of a child from placement.
- c. When there is evidence of neglect or physical or sexual abuse.

**202.13(2)** The department may remove a child from a facility when any of the following conditions exist:

- a. There is evidence of abuse, neglect, or exploitation of the child.
- b. The child needs a specialized service that the facility does not offer.
- c. The child is unable to benefit from the placement as evidenced by lack of progress of the child.
- d. There is evidence the facility is unable to provide the care needed by the child and fulfill its responsibilities under the case plan.
- e. There is lack of cooperation of the facility with the department.

**202.13(3)** If a foster family objects in writing within seven days from the date that the department furnishes notice of plans to remove the child, the service area manager or designee shall grant a conference to the foster family to determine whether the removal is in the child's best interest.

a. This conference shall not be construed to be a contested case under the Iowa administrative procedure Act, Iowa Code chapter 17A.

b. The conference shall be provided before the child is removed except in instances listed in 202.13(1) "a" to "c." The service area manager or designee shall review the propriety of the removal and explain the decision to the foster family.

c. The service area manager or designee, on finding that the removal is not in the child's best interests, may overrule the removal decision unless a court order or parental decision prevents the department from doing so.

**202.13(4)** When the facility requests a child be removed from its care, it shall give a minimum of ten days' notice to the department so planning may be made on behalf of the child.

This rule is intended to implement Iowa Code section 234.6(6) "b."  
[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—202.14(234) Termination.** The foster care services shall be terminated when the child is no longer an eligible child, or when the attainment of goals in the case plan has been achieved, or when the goals for whatever reasons cannot be achieved, or when it is evident that the family or individual is unable to benefit from the service or unwilling to accept further services.

This rule is intended to implement Iowa Code section 234.6(6) "b."

**441—202.15(234) Case permanency plan.**

**202.15(1)** The department worker shall ensure that a case permanency plan is developed for each child who is placed in foster care if the department has agreed to provide foster care through a voluntary placement agreement, if a court has transferred custody or guardianship to the department for the purpose

of foster care, or if a court has placed the child in foster care and ordered the department to supervise the placement.

**202.15(2)** The department worker shall develop the case permanency plan with the child's parents, unless the child's parents are unwilling to participate in the plan's development, and with the child, unless the child is unable or unwilling to participate. For a child 14 years of age or older in foster care, the case permanency plan must be developed in consultation with the child. The child may choose up to two members of the case planning team who are not the child's foster parent or caseworker. The department may reject an individual selected by a child at any time if the department has good cause to believe the individual would not act in the best interests of the child. One individual selected by the child to be a member of a child's case planning team may be designated to be the child's advisor and, as necessary, advocate with respect to the use of the reasonable and prudent parent standard.

**202.15(3)** The department worker shall be responsible for ensuring the development of the case permanency plan within the time frames specified in rule 441—130.7(234). In all cases, the case permanency plan shall be completed within 60 days of the date the child entered foster care.

**202.15(4)** Copies of the initial and subsequent case permanency plans shall be provided to the child, the child's parents, and the foster care provider. Copies shall also be provided to the following, if involved in services to the child: the juvenile court officer, the judge, the child's attorney, the child's guardian ad litem, the child's guardian, the child's custodian, the child's court-appointed special advocate, the parents' attorneys, the county attorney, the state foster care review board, and any other interested parties identified in the plan.

**202.15(5)** The initial and subsequent case permanency plans shall be completed on the forms specified in rule 441—130.7(234).

**202.15(6)** Rescinded IAB 4/28/04, effective 6/2/04.  
[ARC 2069C, IAB 8/5/15, effective 10/1/15]

**441—202.16(135H) Department approval of need for a psychiatric medical institution for children.**

**202.16(1)** Applicants for departmental approval of need shall submit the following to the division of child and family services:

*a.* A description of the population to be served, including age, sex, and types of disorders, and an estimate of the number of these youth in need of psychiatric care in the area of the state in which the applicant is located.

*b.* A statement of the number of beds requested and a description of the treatment program to be provided, the outcomes to be achieved and the techniques for measuring outcomes.

*c.* A proposed date of operation as a psychiatric medical institution for children.

*d.* A description of the applicant's experience with providing similar services to youth, especially the target population.

*e.* A description of the applicant's plan, including the timeline for achieving accreditation to provide psychiatric services from a federally recognized accrediting organization under the organization's standards for residential settings and licensure as a psychiatric medical institution for children, or a copy of the organization's report if already accredited.

*f.* References from the service area manager for the department service area in which the proposed psychiatric medical institution for children would be located, the chief juvenile court officer of the judicial district in which the proposed psychiatric medical institution for children would be located and the applicant's licenser from the department of inspections and appeals or department of public health.

**202.16(2)** The department shall evaluate proposals and issue a decision based on the following criteria:

*a.* The number of psychiatric medical institutions for children beds for the proposed population which are needed in the area of the state in which the facility would be located, based on the department's most recent needs assessment.

*b.* The steps the facility has taken towards achieving accreditation from a federally recognized accrediting organization and licensure as a psychiatric medical institution for children.

c. The applicant's ability to provide services and support consistent with the requirements under Iowa Code chapter 232 including, but not limited to, evidence that:

- (1) Children will be served in a setting which is in close proximity to their parents' home.
- (2) Each child will receive services consistent with the child's best interests and special psychiatric needs as identified in the child's case permanency plan.
- (3) Children and their families will receive services to facilitate the children's return home or other permanent placement.

d. The applicant's ability to provide children with a non-hospital-type living environment if the applicant is not freestanding from a hospital or health care facility.

e. The limits on the number of beds found in Iowa Code section 135H.6, subsection 5.

**202.16(3)** If a facility has not been licensed as a psychiatric medical institution for children within one year after the date of the department's approval of need, the department's approval shall expire unless the department has approved an extension. An extension may be approved up to a maximum of six months if the agency has documented extenuating circumstances which prevented completion of the licensing process.

This rule is intended to implement Iowa Code section 135H.6.

#### **441—202.17(232) Area group care targets.**

**202.17(1)** *Area target.* A group care budget target shall be established for each departmental service area, which shall be based on the annual statewide group care appropriation established by the general assembly.

a. The department and the judicial branch shall jointly develop a formula for allocating the group care appropriation among the departmental service areas. The formula shall be based on:

- (1) Proportional child population.
- (2) Proportional group foster care usage in the previous five completed fiscal years.
- (3) Other indicators of need.

b. Any portion of the group care appropriation allocated for 50 highly structured juvenile program beds and not used may be used for group care.

c. Upon written agreement of the affected service area managers and chief juvenile court officers, service areas may transfer part of their group care budget from one service area to another. A service area may exceed its budget target figure up to 5 percent during the fiscal year, providing that the overall funding allocation by the department for all child welfare services in the service area is not exceeded.

d. Notwithstanding the statewide appropriation established in this subrule, a budget established in a service area's group care plan pursuant to Iowa Code section 232.143 may be exceeded, a group care placement may be ordered, and state payment may be made if the review organization finds that the placement is necessary to meet the child's service needs and if the service area has additional funds transferred from another service area or if the service area is within 5 percent of its group care budget target figure pursuant to 441—paragraph 202.17(1)“c.”

The department and juvenile court services shall work together to ensure that a service area's group care expenditures shall not exceed the funds allocated to the service area for group care in the fiscal year.

e. If at any time after September 30, 1998, annualization of a service area's current expenditures indicates a service area is at risk of exceeding its group foster care expenditure target under Iowa Code section 232.143 by more than 5 percent, the department and juvenile court services shall examine all group foster care placements in that service area in order to identify those which might be appropriate for termination. In addition, any aftercare services believed to be needed for the children whose placements may be terminated shall be identified.

The department and juvenile court services shall initiate action to set dispositional review hearings for the placements identified. In the dispositional review hearing, the juvenile court shall determine whether needed aftercare services are available and whether termination of the placement is in the best interest of the child and the community.

**202.17(2)** *Plan for achieving target.* For each of the departmental service areas, representatives appointed by the department and juvenile court services shall establish a plan for containing the

expenditure for children placed in group care within the budget target allocated to that service area. The plan shall include monthly targets and strategies for developing alternatives to group care placements.

The plans shall also ensure potential group care referrals are reviewed by the review organization prior to submission of a recommendation for group care placement to the court.

Each area plan shall be established in advance of the fiscal year to which the plan applies. To the extent possible, the department and the juvenile court shall coordinate the planning required under this subrule with planning for services paid under Iowa Code section 232.141, subsection 4. The department's service area manager shall communicate regularly, as specified in the area plan, with the juvenile courts within the service area concerning the current status of the plan's implementation.

This rule is intended to implement Iowa Code section 232.143.

**441—202.18(235) Local transition committees.** Local transition committees shall be established in each of the department service areas. The service area manager or designee shall determine the number of local transition committees needed within the service area, set operating policies and procedures, and appoint committee membership.

**202.18(1) Purpose.** The purpose of local transition committees, as established by Iowa Code Supplement section 235.7, is to ensure that the transition needs of youth in foster care who are 16 years of age or older have been addressed in order to assist the youth in preparing for the transition from foster care to adulthood.

**202.18(2) Membership.** Each committee shall have a designated number of members.

*a.* The standing committee membership may include, but is not limited to:

- (1) Department staff involved with child welfare, adult services, or transition planning.
- (2) Juvenile court services staff.
- (3) Adult service system staff.
- (4) Education staff.
- (5) Service care provider representation.
- (6) Others knowledgeable about community resources.

*b.* Additionally, nonstanding membership may include those knowledgeable about the youth, including the child's court-appointed special advocate, guardian ad litem, and service or care providers.

*c.* In areas where teams or boards already in existence are involved in review and planning for youth needs, such as the foster care review board or child welfare funding decategorization boards, such teams or boards may serve as local transition committees.

**202.18(3) Duties.** Local transition committees shall address the transition needs of youth in foster care who are 16 years of age or older and who have a case permanency plan as defined in Iowa Code Supplement section 232.2. Each committee shall have operating policies and procedures to carry out the duties below.

*a.* Each committee shall establish a process for review and approval of written transition plans for youth for whom the committee has placement responsibility that meets a continuum of case needs and coordinates with local transition planning protocol. The process may include a paper review or an in-person review, or both, according to case need.

*b.* The committee may be involved when the youth is at least 16 years of age, but shall be involved in reviewing and approving a youth's transition plan before the youth reaches age 17½. When a youth enters foster care at age 17½ or older, the committee shall be involved in reviewing and approving the youth's transition plan within 30 days of completion.

*c.* In reviewing a youth's transition plan, the committee shall identify and act to address gaps existing in services or supports available that would assist the youth in the transition from foster care to adulthood.

*d.* For those youth expected to need services as adults, the committee shall ensure that the transition plan was developed with the participation of any person reasonably expected to be a service provider when the youth becomes an adult or to become responsible for the costs of services at that time.

*e.* The committee shall ensure that transition planning and review is coordinated with overall case planning and review. Committee review and approval shall be indicated in the youth's case permanency plan.

*f.* With respect to meetings involving a specific youth receiving foster care and the youth's family, the local transition committees are not subject to Iowa Code chapter 21.

*g.* The information and records of or provided to a local transition committee regarding a youth receiving foster care and the youth's family are not public records pursuant to Iowa Code chapter 22 when the records relate to the foster care placement and transition needs of the youth.

*h.* Members of the committees are subject to the standards of confidentiality set forth in Iowa Code sections 600.16, 217.30 and 235A.15.

**202.18(4) Report.** The service area manager or designee shall submit a report on transition planning committees to the department's division of child and family services. The report shall be submitted annually by October 1 for the immediately preceding fiscal year. The report shall include, but not be limited to, the following:

- a.* The geographical area covered for each committee within the service area.
- b.* Standing committee membership for each committee.
- c.* The number of cases reviewed by each committee.
- d.* Identification of barriers to successful transition and gaps in community services or supports.
- e.* Suggestions for ways to transition youth from foster care to adulthood more effectively.

This rule is intended to implement Iowa Code Supplement section 235.7.

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## **ENVIRONMENTAL PROTECTION COMMISSION[567]**

Former Water, Air and Waste Management[900], renamed by 1986 Iowa Acts, chapter 1245, Environmental Protection Commission under the “umbrella” of the Department of Natural Resources.

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## CHAPTER 20

## SCOPE OF TITLE—DEFINITIONS—FORMS—RULES OF PRACTICE

[Prior to 12/3/86, Water, Air and Waste Management[900]]

**567—20.1(455B,17A) Scope of title.** The department has jurisdiction over the atmosphere of the state to prevent, abate and control air pollution, by establishing standards for air quality and by regulating potential sources of air pollution through a system of general rules or specific permits. The construction and operation of any new or existing stationary source which emits or may emit any air pollutant requires a specific permit from the department, unless exempted by the department.

This chapter provides general definitions applicable to this title and rules of practice, including forms, applicable to the public in the department's administration of the subject matter of this title.

Chapter 21 contains the provisions requiring compliance schedules, allowing for variances, and setting forth the emission reduction program. Chapter 22 contains the standards and procedures for the permitting of emission sources. Chapter 23 contains the air emission standards for contaminants. Chapter 24 provides for the reporting of excess emissions and the equipment maintenance and repair requirements. Chapter 25 contains the testing and sampling requirements for new and existing sources. Chapter 26 identifies air pollution emergency episodes and the preplanned abatement strategies. Chapter 27 sets forth the conditions political subdivisions must meet in order to secure acceptance of a local air pollution control program. Chapter 28 identifies the state ambient air quality standards. Chapter 29 sets forth the qualifications for an observer for reading visible emissions. Chapter 30 sets forth requirements to pay fees for specified activities. Chapter 31 contains the conformity of general federal actions to the Iowa state implementation plan or federal implementation plan and requirements for areas designated nonattainment. Chapter 32 specifies requirements for conducting the animal feeding operations field study. Chapter 33 contains special regulations and construction permit requirements for major stationary sources and includes the requirements for prevention of significant deterioration (PSD). Chapter 34 contains provisions for air quality emissions trading programs.

All dates specified in reference to the Code of Federal Regulations (CFR) are the dates of publication of the last amendments to the portion of the CFR being cited.

[ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—20.2(455B) Definitions.** For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 455B.411 shall be considered to be incorporated verbatim in these rules.

*"Air pollution alert"* means that action condition declared when the concentrations of air contaminants reach the level at which the first stage control actions are to begin.

*"Air pollution emergency"* means that action condition declared when the air quality is continuing to degrade to a level that should never be reached, and that the most stringent control actions are necessary.

*"Air pollution episode"* means a combination of forecast or actual meteorological conditions and emissions of air contaminants which may or do present an imminent and substantial endangerment to the health of persons, during which the chief meteorological factors are the absence of winds that disperse air contaminants horizontally and a stable atmospheric layer which tends to inhibit vertical mixing through relatively deep layers.

*"Air pollution forecast"* means an air stagnation advisory issued to the department, the commission, and to appropriate air pollution control agencies by an authorized Air Stagnation Advisory Office of the National Weather Service predicting that meteorological conditions conducive to an air pollution episode may be imminent. This advisory may be followed by a prediction of the duration and termination of such meteorological conditions.

*"Air pollution warning"* means that action condition declared when the air quality is continuing to degrade from the levels classified as an air pollution alert, and where control actions in addition to those conducted under an air pollution alert are necessary.

“*Air quality standard*” means an allowable level of air contaminant or atmospheric air concentration established by the commission.

“*Ambient air*” means that portion of the atmosphere, external to buildings, to which the general public has access. Ambient air does not include the atmosphere over land owned or controlled by the source and to which public access is precluded by a fence or other physical barriers.

“*Anaerobic lagoon*” means an impoundment, the primary function of which is to store and stabilize organic wastes. The impoundment is designed to receive wastes on a regular basis and the design waste loading rates are such that the predominant biological activity in the impoundment will be anaerobic. An anaerobic lagoon does not include:

a. A runoff control basin which collects and stores only precipitation induced runoff from an open feedlot feeding operation; or

b. A waste slurry storage basin which receives waste discharges from confinement feeding operations and which is designed for complete removal of accumulated wastes from the basin at least semiannually; or

c. Any anaerobic treatment system which includes collection and treatment facilities for all off gases.

“*ASME*” means the American Society of Mechanical Engineers.

“*ASTM*” means the American Society for Testing and Materials.

“*Auxiliary fuel firing equipment*” means equipment to supply additional heat, by the combustion of an auxiliary fuel, for the purpose of attaining temperatures sufficient to dry and ignite the waste material, to maintain ignition thereof, and to promote complete combustion of combustible gases, solids and vapors.

“*Backyard burning*” means the disposal of residential waste by open burning on the premises of the property where such waste is generated.

“*Biodiesel fuel*” means a renewable, biodegradable, mono alkyl ester combustible liquid fuel derived from agricultural plant oils or animal fat such as, but not limited to, soybean oil. For purposes of this definition, “biodiesel fuel” must also meet the specifications of American Society for Testing and Material Specifications (ASTM) D 6751-02, “Standard Specification for Biodiesel Fuel (B100) Blend Stock for Distillate Fuels,” and be registered with the U.S. Environmental Protection Agency as a fuel and a fuel additive under Section 211(b) of the Clean Air Act, 42 U.S.C. Sections 7401, et seq. as amended through November 15, 1990.

“*Btu*” means British thermal unit, the quantity of heat required to raise the temperature of one pound of water from 59°F to 60°F.

“*Carbonaceous fuel*” means any form of combustible matter (whether solid, liquid, vapor or gas) consisting primarily of carbon-containing compounds in either fixed or volatile form, and which is burned primarily for its heat content.

“*Chimney or stack*” means any flue, conduit or duct permitting the discharge or passage of air contaminants into the open air, or constructed or arranged for this purpose.

“*COH/1,000 linear feet*” means coefficient of haze per 1,000 linear feet, which is a measure of the optical density of a filtered deposit of particulate matter as given in ASTM Standard D-1704-61, and indicated by the following formula:

$$\text{COH/1,000 linear feet} = \frac{(\text{Area tape, ft}^2)(100,000)}{(\text{Volume of air sample, ft}^3)} \log \frac{100}{\% \text{ transmission}}$$

“*Combustion for indirect heating*” means the combustion of fuel to produce usable heat that is to be transferred through a heat-conducting materials barrier or by a heat storage medium to a material to be heated so that the material being heated is not contacted by, and adds no substance to, the products of combustion.

“*Control equipment*” means any equipment that has the function to prevent the formation of or the emission to the atmosphere of air contaminants from any fuel burning, incinerator or process equipment.

“*Country grain elevator*” shall have the same definition as “country grain elevator” set forth in 567—subrule 22.10(1).

“*Criteria*” means information used as guidelines for decisions when establishing air quality goals, air quality standards and the various air quality levels, and which in no case is to be confused or used interchangeably with air quality goals or standards.

“*Diesel fuel*” means a low sulfur fuel oil that complies with the specifications for grade 1-D or 2-D, as defined by the American Society of Testing and Materials (ASTM) D 975-02, “Standard Specification for Diesel Fuel Oils,” grade 1-GT or 2-GT, as defined by ASTM D 2880-00, “Standard Specification for Gas Turbine Fuel Oils,” or grade 1 or 2, as defined by ASTM D 396-02, “Standard Specification for Fuel Oils.”

1. For purposes of the air quality rules contained in Title II, and unless otherwise specified, diesel fuel may contain a blend of up to 2.0 percent biodiesel fuel, by volume, as “biodiesel fuel” is defined in this rule.

2. The department shall consider air pollutant emissions calculations for the biodiesel fuel blends specified in numbered paragraph “1” to be equivalent to the air pollutant emissions calculations for unblended diesel fuel.

3. Construction permits or operating permits issued under 567—Chapter 22 which restrict equipment fuel use to diesel fuel shall be considered by the department to include the biodiesel fuel blends specified in numbered paragraph “1,” unless otherwise specified in 567—Chapter 22 or in a permit issued under 567—Chapter 22.

“*Director*” means the director of the department of natural resources or the director’s designee.

“*Electric furnace*” means a furnace in which the melting and refining of metals are accomplished by means of electrical energy.

“*Emergency generator*” means any generator of which the sole function is to provide emergency backup power during an interruption of electrical power from the electric utility. An emergency generator does not include:

1. Peaking units at electric utilities; or
2. Generators at industrial facilities that typically operate at low rates, but are not confined to emergency purposes; or
3. Any standby generators that are used during time periods when power is available from the electric utility.

An emergency is an unforeseeable condition that is beyond the control of the owner or operator.

“*Emission limitation*” and “*emission standard*” mean a requirement established by a state, local government, or the administrator which limits the quantity, rate or concentration of emissions of air pollutants on a continuous basis, including any requirements which limit the level of opacity, prescribe equipment, set fuel specifications or prescribe operation or maintenance procedures for a source to ensure continuous emission reduction.

“*EPA conditional method*” means any method of sampling and analyzing for air pollutants that has been validated by the administrator but that has not been published as an EPA reference method.

“*EPA reference method*” means the following methods used for performance tests and continuous monitoring systems:

1. Performance test (stack test). A stack test shall be conducted according to EPA reference methods specified in 40 CFR 51, Appendix M (as amended through December 21, 2010); 40 CFR 60, Appendix A (as amended through September 9, 2010); 40 CFR 61, Appendix B (as amended through October 17, 2000); and 40 CFR 63, Appendix A (as amended through August 20, 2010).

2. Continuous monitoring systems. Minimum performance specifications and quality assurance procedures for performance evaluations of continuous monitoring systems are as specified in 40 CFR 60, Appendix B (as amended through September 9, 2010); 40 CFR 60, Appendix F (as amended through September 9, 2010); 40 CFR 75, Appendix A (as amended through March 28, 2011); 40 CFR 75, Appendix B (as amended through March 28, 2011); and 40 CFR 75, Appendix F (as amended through March 28, 2011).

*“Equipment”* means equipment capable of emitting air contaminants to produce air pollution such as fuel burning, combustion or process devices or apparatus including but not limited to fuel-burning equipment, refuse burning equipment used for the burning of fuel or other combustible material from which the products of combustion are emitted; and including but not limited to apparatus, equipment or process devices which generate heat and may emit products of combustion, and manufacturing, chemical, metallurgical or mechanical apparatus or process devices which may emit smoke, particulate matter or other air contaminants.

*“Excess air”* means that amount of air supplied in addition to the theoretical quantity necessary for complete combustion of all fuel or combustible waste material present.

*“Excess emission”* means any emission which exceeds any applicable emission standard prescribed in 567—Chapter 23 or rule 567—22.4(455B), 567—22.5(455B), 567—31.3(455B), or 567—33.3(455B) or any emission limit specified in a permit or order.

*“Existing equipment”* means equipment, machines, devices or installations that are in operation prior to September 23, 1970.

*“Foundry cupola”* means a stack-type furnace used for melting of metals consisting of, but not limited to, the furnace proper, tuyeres, fans or blowers, tapping spout, charging equipment, gas cleaning devices and other auxiliaries.

*“Fugitive dust”* means any airborne solid particulate matter emitted from any source other than a flue or stack.

*“Garbage”* means all solid and semisolid putrescible and nonputrescible animal and vegetable wastes resulting from the handling, preparing, cooking, storing and serving of food or of material intended for use as food, but excluding recognized industrial by-products.

*“Gas cleaning device”* means a facility designed to remove air contaminants from gases exhausted from equipment as defined herein.

*“Goal”* means a level of air quality which is expected to be obtained.

*“Grain processing”* means the equipment, or the combination of different types of equipment, used in the processing of grain to produce a product primarily for wholesale or retail sale for human or animal consumption, including the processing of grain for production of biofuels, except for “feed mill equipment,” as “feed mill equipment” is defined in rule 567—22.10(455B).

*“Grain storage elevator”* means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and that is 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 (grain storage capacity which is inside a building, bin, or silo) of more than 35,200 m<sup>3</sup> (ca. 1 million U.S. bushels).

*“Greenhouse gas”* means carbon dioxide, methane, nitrous oxide, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride.

*“Heating value”* means the heat released by combustion of one pound of waste or fuel measured in Btu on an as received basis. For solid fuels, the heating value shall be determined by use of ASTM Standard D2015-66.

*“Incinerator”* means a combustion apparatus designed for high temperature operation in which solid, semisolid, liquid or gaseous combustible refuse is ignited and burned efficiently, and from which the solid residues contain little or no combustible material.

*“Initiation of construction, installation or alteration”* means significant permanent modification of a site to install equipment, control equipment or permanent structures. Not included are activities incident to preliminary engineering, environmental studies, or acquisition of a site for a facility.

*“Landscape waste”* means any vegetable or plant wastes except garbage. The term includes trees, tree trimmings, branches, stumps, brush, weeds, leaves, grass, shrubbery and yard trimmings.

*“Level”* means a certain specified degree, quality or characteristic.

*“Malfunction”* means any sudden and unavoidable failure of control equipment or of a process to operate in a normal manner. Any failure that is caused entirely or in part by poor maintenance, careless operation, lack of an adequate maintenance program, or any other preventable upset condition or preventable equipment breakdown shall not be considered a malfunction.

“*Maximum achievable control technology (MACT)*” means the following regarding regulated hazardous air pollutant sources:

1. For existing sources, the emissions limitation reflecting the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any non-air quality health and environmental impacts and energy requirements, determines is achievable by sources in the category of stationary sources, that shall not be less stringent than the MACT floor.

2. For new sources, the emission limitation which is not less stringent than the emission limitation achieved in practice by the best-controlled similar source and which reflects the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any non-air quality health and environmental impacts and energy requirements, determines is achievable by the affected source.

“*Maximum achievable control technology (MACT) floor*” means the following:

1. For existing sources, the average emission limitation achieved by the best 12 percent of the existing sources in the United States (for which the administrator or the department has or could reasonably obtain emissions information), excluding those sources that have, within 18 months before the emission standard is proposed or within 30 months before such standard is promulgated, whichever is later, first achieved a level of emission rate or emission reduction which complies, or would comply if the source is not subject to such standard, with the lowest achievable emission rate applicable to the source category and prevailing at the time, for categories and subcategories of stationary sources with 30 or more sources in the category or subcategory, or the average emission limitation achieved by the best-performing five sources in the United States (for which the administrator or the department has or could reasonably obtain emissions information), for a category or subcategory of stationary sources with fewer than 30 sources in the category or subcategory.

2. For new sources, the emission limitation achieved in practice by the best-controlled similar source.

“*New equipment*” means except for any equipment or modified equipment to which 567—subrule 23.1(2) applies, any equipment or control equipment not under construction or for which components have not been purchased on or before September 23, 1970, and any equipment which is altered or modified after such date, which may cause the emission of air contaminants or eliminate, reduce or control the emission of air contaminants.

“*Number 1 fuel oil*” and “*number 2 fuel oil*,” also known as “distillate oil,” mean fuel oil that complies with the specifications for fuel oil number 1 or fuel oil number 2, as defined by the American Society of Testing and Materials (ASTM) D 396-02, “Standard Specification for Fuel Oils.”

1. For purposes of the air quality rules contained in Title II, and unless otherwise specified, number 1 fuel oil or number 2 fuel oil may contain a blend of up to 2.0 percent biodiesel fuel, by volume, as “biodiesel fuel” is defined in this rule.

2. The department shall consider air pollutant emissions calculations for the biodiesel fuel blends specified in numbered paragraph “1” to be equivalent to the air pollutant emissions calculations for unblended number 1 fuel oil or unblended number 2 fuel oil.

3. Construction permits or operating permits issued under 567—Chapter 22 which restrict equipment fuel use to number 1 fuel oil or number 2 fuel oil shall be considered by the department to include the biodiesel fuel blends specified in numbered paragraph “1,” unless otherwise specified in 567—Chapter 22 or in a permit issued under 567—Chapter 22.

“*Objective*” means a certain specified degree, quality or characteristic expected to be attained.

“*Odor*” means that which produces a response of the human sense of smell to an odorous substance.

“*Odorous substance*” means a gaseous, liquid, or solid material that elicits a physiological response by the human sense of smell.

“*Odorous substance source*” means any equipment, installation operation, or material which emits odorous substances; such as, but not limited to, a stack, chimney, vent, window, opening, basin, lagoon, pond, open tank, storage pile, or inorganic or organic discharges.

“*One-hour period*” means any 60-minute period commencing on the hour.

“*Opacity*” means the degree to which emissions reduce the transmission of light and obscure the view of an object in the background (See 567—Chapter 29).

“*Open burning*” means any burning of combustible materials where the products of combustion are emitted into the open air without passing through a chimney or stack.

“*Particulate matter*” (except for the purposes of new source performance standards as defined in 40 CFR 60) means any material, except uncombined water, that exists in a finely divided form as a liquid or solid at standard conditions and includes gaseous emissions that condense to liquid or solid form as measured by EPA-approved reference methods.

“*Parts per million (PPM)*” means a term which expresses the volumetric concentration of one material in one million unit volumes of a carrier material.

“*Plan documents*” means the reports, proposals, preliminary plans, survey and basis of design data, general and detail construction plans, profiles, specifications and all other information pertaining to equipment.

“*PM<sub>10</sub>*” means particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers as measured by an EPA-approved reference method.

“*PM<sub>2.5</sub>*” means particulate matter as defined in this rule with an aerodynamic diameter less than or equal to a nominal 2.5 micrometers as measured by an EPA-approved reference method.

“*Potential to emit*” means the maximum capacity of a stationary source to emit any air pollutant under its physical and operational design. Any physical or operational limitation on the capacity of a source to emit an air pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation is enforceable by the administrator. This term does not alter or affect the use of this term for any other purposes under the Act, or the term “capacity factor” as used in Title IV of the Act or the regulations relating to acid rain.

For the purpose of determining potential to emit for country grain elevators, the provisions set forth in 567—subrule 22.10(2) shall apply.

For purposes of calculating potential to emit for emergency generators, “maximum capacity” means one of the following:

1. 500 hours of operation annually, if the generator has actually been operated less than 500 hours per year for the past five years;
2. 8,760 hours of operation annually, if the generator has actually been operated more than 500 hours in one of the past five years; or
3. The number of hours specified in a state or federally enforceable limit.

If the source is subject to new source construction permit review, then potential to emit is defined as stated above or as established in a federally enforceable permit.

“*Privileged communication*” means information other than air pollutant emissions data the release of which would tend to affect adversely the competitive position of the owner or operator of the equipment.

“*Process*” means any action, operation or treatment, and all methods and forms of manufacturing or processing, that may emit smoke, particulate matter, gaseous matter or other air contaminant.

“*Process weight*” means the total weight of all materials introduced into any source operation. Solid fuels charged will be considered as part of the process weight, but liquid and gaseous fuels and combustion air will not.

“*Process weight rate*” means continuous or long-run steady-state source operations, the total process weight for the entire period of continuous operation or for a typical portion thereof, divided by the number of hours of such period or portion thereof; or for a cyclical or batch source operation, the total process weight for a period that covers a complete operation or an integral number of cycles, divided by the number of hours of actual process operation during such a period. Where the nature of any process or operation, or the design of any equipment is such as to permit more than one interpretation of this definition, the interpretation that results in the minimum value for allowable emission shall apply.

“*Refuse*” means garbage, rubbish and all other putrescible and nonputrescible wastes, except sewage and water-carried trade wastes.

“*Residential waste*” means any refuse generated on the premises as a result of residential activities. The term includes landscape waste grown on the premises or deposited thereon by the elements, but excludes garbage, tires, trade wastes, and any locally recyclable goods or plastics.

“*Rubbish*” means all waste materials of nonputrescible nature.

“*Salvage operations*” means any business, industry or trade engaged wholly or in part in salvaging or reclaiming any product or material, including, but not limited to, chemicals, drums, metals, motor vehicles or shipping containers.

“*Shutdown*” means the cessation of operation of any control equipment or process equipment or process for any purpose.

“*Six-minute period*” means any one of the ten equal parts of a one-hour period.

“*Smoke*” means gas-borne particles resulting from incomplete combustion, consisting predominantly, but not exclusively, of carbon, and other combustible material, or ash, that form a visible plume in the air.

“*Smoke monitor*” means a device using a light source and a light detector which can automatically measure and record the light-obscuring power of smoke at a specific location in the flue or stack of a source.

“*Source operation*” means the last operation preceding the emission of an air contaminant, and which results in the separation of the air contaminant from the process materials or in the conversion of the process materials into air contaminants, but is not an air pollution control operation.

“*Standard conditions*” means a temperature of 68°F and a pressure of 29.92 inches of mercury absolute.

“*Standard cubic foot (SCF)*” means the volume of one cubic foot of gas at standard conditions.

“*Standard metropolitan statistical area (SMSA)*” means an area which has at least one city with a population of at least 50,000 and such surrounding areas as geographically defined by the U.S. Bureau of the Budget (Department of Commerce).

“*Startup*” means the setting into operation of any control equipment or process equipment or process for any purpose.

“*Stationary source*” means any building, structure, facility or installation which emits or may emit any air pollutant.

“*Theoretical air*” means the exact amount of air required to supply the required oxygen for complete combustion of a given quantity of a specific fuel or waste.

“*Total suspended particulate*” means particulate matter as defined in this rule.

“*Trade waste*” means any refuse resulting from the prosecution of any trade, business, industry, commercial venture (including farming and ranching), or utility or service activity, and any governmental or institutional activity, whether or not for profit.

“*12-month rolling period*” means a period of 12 consecutive months determined on a rolling basis with a new 12-month period beginning on the first day of each calendar month.

“*Untreated*” as it refers to wood or wood products includes only wood or wood products that have not been treated with compounds such as, but not limited to, paint, pigment-stain, adhesive, varnish, lacquer, or resin or that have not been pressure treated with compounds such as, but not limited to, chromate copper acetate, pentachlorophenol or creosote. “Untreated” as it refers to seeds, pellets or other vegetative matter includes only seeds, pellets or other vegetative matter that has not been treated with pesticides or fungicides.

“*Urban area*” means any Iowa city of 100,000 or more population in the current census and all Iowa cities contiguous to such city.

“*Variance*” means a temporary waiver from rules or standards governing the quality, nature, duration or extent of emissions granted by the commission for a specified period of time.

“*Volatile organic compounds*” or “*VOC*” means any compound included in the definition of “volatile organic compounds” found at 40 CFR Section 51.100(s) as amended through March 27, 2014. [ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 1913C, IAB 3/18/15, effective 4/22/15]

**567—20.3(455B) Air quality forms generally.** Rescinded **ARC 1913C**, IAB 3/18/15, effective 4/22/15.

These rules are intended to implement Iowa Code section 17A.3 and chapter 455B, division II.

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- [Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]
- [Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective 12/16/15]

<sup>1</sup> Effective date of 20.2(455B), definition of “12-month rolling period,” delayed 70 days by the Administrative Rules Review Committee at its meeting held October 10, 1995; delay lifted by this Committee December 13, 1995, effective December 14, 1995.

CHAPTER 22  
CONTROLLING POLLUTION

[Prior to 7/1/83, DEQ Ch 3]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

**567—22.1(455B) Permits required for new or existing stationary sources.**

**22.1(1) Permit required.** Unless exempted in subrule 22.1(2) or to meet the parameters established in paragraph “c” of this subrule, no person shall construct, install, reconstruct or alter any equipment, control equipment or anaerobic lagoon without first obtaining a construction permit, or permit pursuant to rule 567—22.8(455B), or permits required pursuant to rules 567—22.4(455B), 567—22.5(455B), 567—31.3(455B), and 567—33.3(455B) as required in this subrule. A permit shall be obtained prior to the initiation of construction, installation or alteration of any portion of the stationary source or anaerobic lagoon.

*a.* Existing sources. Sources built prior to September 23, 1970, are not subject to this subrule, unless they have been modified, reconstructed, or altered on or after September 23, 1970.

*b.* New or reconstructed major sources of hazardous air pollutants. No person shall construct or reconstruct a major source of hazardous air pollutants, as defined in 40 CFR 63.2 and 40 CFR 63.41 as amended through April 22, 2004, unless a construction permit has been obtained from the department, which requires maximum achievable control technology for new sources to be applied. The permit shall be obtained prior to the initiation of construction or reconstruction of the major source.

*c.* New, reconstructed, or modified sources may initiate construction prior to issuance of the construction permit by the department if they meet the eligibility requirements stated in subparagraph (1) below. The applicant must assume any liability for construction conducted on a source before the permit is issued. In no case will the applicant be allowed to hook up the equipment to the exhaust stack or operate the equipment in any way that may emit any pollutant prior to receiving a construction permit.

(1) Eligibility.

1. The applicant has submitted a construction permit application to the department, as specified in subrule 22.1(3);

2. The applicant has notified the department of the applicant’s intentions in writing five working days prior to initiating construction; and

3. The source is not subject to rule 567—22.4(455B), 567—subrule 23.1(2), 567—subrule 23.1(3), 567—subrule 23.1(4), 567—subrule 23.1(5), or paragraph “b” of this subrule. Prevention of significant deterioration (PSD) provisions and prohibitions remain applicable until a proposed project legally obtains PSD synthetic minor status (i.e., obtains permitted limits which limit the source below the PSD thresholds).

(2) The applicant must cease construction if the department’s evaluation demonstrates that the construction, reconstruction or modification of the source will interfere with the attainment or maintenance of the national ambient air quality standards or will result in a violation of a control strategy required by 40 CFR Part 51, Subpart G, as amended through August 12, 1996.

(3) The applicant will be required to make any modification to the source that may be imposed in the issued construction permit.

(4) The applicant must notify the department of the date that construction or reconstruction actually started. All notifications shall be submitted to the department in writing no later than 30 days after construction or reconstruction started. All notifications shall include all of the information listed in 22.3(3) “b.”

*d.* Permit requirements for country grain elevators, country grain terminal elevators, grain terminal elevators, and feed mill equipment. The owner or operator of a country grain elevator, country grain terminal elevator, grain terminal elevator or feed mill equipment, as “country grain elevator,” “country grain terminal elevator,” “grain terminal elevator,” and “feed mill equipment” are defined in subrule 22.10(1), may elect to comply with the requirements specified in rule 567—22.10(455B) for equipment at these facilities.

**22.1(2) Exemptions.** The requirement to obtain a permit in subrule 22.1(1) is not required for the equipment, control equipment, and processes listed in this subrule. The permitting exemptions in this subrule do not relieve the owner or operator of any source from any obligation to comply with any other applicable requirements. Equipment, control equipment, or processes subject to rule 567—22.4(455B) and 567—Chapter 33, prevention of significant deterioration requirements, or rule 567—22.5(455B) or 567—31.3(455B), requirements for nonattainment areas, may not use the exemptions from construction permitting listed in this subrule. Equipment, control equipment, or processes subject to 567—subrule 23.1(2), new source performance standards (40 CFR Part 60 NSPS); 567—subrule 23.1(3), emission standards for hazardous air pollutants (40 CFR Part 61 NESHAP); 567—subrule 23.1(4), emission standards for hazardous air pollutants for source categories (40 CFR Part 63 NESHAP); or 567—subrule 23.1(5), emission guidelines, may still use the exemptions from construction permitting listed in this subrule provided that a permit is not needed to create federally enforceable limits that restrict potential to emit. If equipment is permitted under the provisions of rule 567—22.8(455B), then no other exemptions shall apply to that equipment.

Records shall be kept at the facility for exemptions that have been claimed under the following paragraphs: 22.1(2)“a” (for equipment > 1 million Btu per hour input), 22.1(2)“b,” 22.1(2)“e,” 22.1(2)“r” or 22.1(2)“s.” The records shall contain the following information: the specific exemption claimed and a description of the associated equipment. These records shall be made available to the department upon request.

The following paragraphs are applicable to paragraphs 22.1(2)“g” and “i.” A facility claiming to be exempt under the provisions of paragraph 22.1(2)“g” or “i” shall provide to the department the information listed below. If the exemption is claimed for a source not yet constructed or modified, the information shall be provided to the department at least 30 days in advance of the beginning of construction on the project. If the exemption is claimed for a source that has already been constructed or modified and that does not have a construction permit for that construction or modification, the information listed below shall be provided to the department within 60 days of March 20, 1996. After that date, if the exemption is claimed by a source that has already been constructed or modified and that does not have a construction permit for that construction or modification, the source shall not operate until the information listed below is provided to the department:

- A detailed emissions estimate of the actual and potential emissions, specifically noting increases or decreases, for the project for all regulated pollutants (as defined in rule 567—22.100(455B)), accompanied by documentation of the basis for the emissions estimate;
  - A detailed description of each change being made;
  - The name and location of the facility;
  - The height of the emission point or stack and the height of the highest building within 50 feet;
  - The date for beginning actual construction and the date that operation will begin after the changes are made;
- A statement that the provisions of rules 567—22.4(455B), 567—22.5(455B), and 567—31.3(455B) and 567—Chapter 33 do not apply; and
- A statement that the accumulated emissions increases associated with each change under paragraph 22.1(2)“i,” when totaled with other net emissions increases at the facility contemporaneous with the proposed change (occurring within five years before construction on the particular change commences), have not exceeded significant levels, as defined in 40 CFR 52.21(b)(23) as amended through October 20, 2010, and adopted in rules 567—22.4(455B) and 567—33.3(455B), and will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28. This statement shall be accompanied by documentation for the basis of these statements.

The written statement shall contain certification by a responsible official as defined in rule 567—22.100(455B) of truth, accuracy, and completeness. This certification shall state that, based on information and belief formed after reasonable inquiry, the statements and information in the document are true, accurate, and complete.

*a.* Fuel-burning equipment for indirect heating and reheating furnaces or cooling units using natural gas or liquefied petroleum gas with a capacity of less than ten million Btu per hour input per combustion unit.

*b.* Fuel-burning equipment for indirect heating or cooling with a capacity of less than 1 million Btu per hour input per combustion unit when burning untreated wood, untreated seeds or pellets, other untreated vegetative materials, or fuel oil, provided that the equipment and the fuel meet the conditions specified in this paragraph. Used oils meeting the specification from 40 CFR 279.11 as amended through May 3, 1993, are acceptable fuels for this exemption. When combusting used oils, the equipment must have a maximum rated capacity of 50,000 Btu or less per hour of heat input or a maximum throughput of 3,600 gallons or less of used oils per year. When combusting untreated wood, untreated seeds or pellets, or other untreated vegetative materials, the equipment must have a maximum rated capacity of 265,600 Btu or less per hour or a maximum throughput of 378,000 pounds or less per year of each fuel or any combination of fuels. Records shall be maintained on site by the owner or operator for at least two calendar years to demonstrate that fuel usage is less than the exemption thresholds. Owners or operators initiating construction, installation, reconstruction, or alteration of equipment (as defined in rule 567—20.2(455B)) on or before October 23, 2013, burning coal, used oils, untreated wood, untreated seeds or pellets, or other untreated vegetative materials that qualified for this exemption may continue to claim this exemption after October 23, 2013, without being restricted to the maximum heat input or throughput specified in this paragraph.

*c.* Mobile internal combustion and jet engines, marine vessels and locomotives.

*d.* Equipment used for cultivating land, harvesting crops, or raising livestock other than anaerobic lagoons. This exemption is not applicable if the equipment is used to remove substances from grain which were applied to the grain by another person. This exemption is also not applicable to equipment used by a person to manufacture commercial feed, as defined in Iowa Code section 198.3, which is normally not fed to livestock, owned by the person or another person, in a feedlot, as defined in Iowa Code section 172D.1, subsection 6, or a confinement building owned or operated by that person and located in this state.

*e.* Incinerators and pyrolysis cleaning furnaces with a rated refuse burning capacity of less than 25 pounds per hour for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013. Pyrolysis cleaning furnace exemption is limited to those units that use only natural gas or propane. Salt bath units are not included in this exemption. Incinerators or pyrolysis cleaning furnaces for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall not qualify for this exemption. After October 23, 2013, only paint clean-off ovens with a maximum rated capacity of less than 25 pounds per hour that do not combust lead-containing materials shall qualify for this exemption.

*f.* Fugitive dust controls unless a control efficiency can be assigned to the equipment or control equipment.

*g.* Equipment or control equipment which reduces or eliminates all emission to the atmosphere. If a source wishes to obtain credit for emission reductions, a permit must be obtained for the reduction prior to the time the reduction is made. If a construction permit has been previously issued for the equipment or control equipment, all other conditions of the construction permit remain in effect.

*h.* Equipment (other than anaerobic lagoons) or control equipment which emits odors unless such equipment or control equipment also emits particulate matter, or any other regulated air contaminant (as defined in rule 567—22.100(455B)).

*i.* Initiation of construction, installation, reconstruction, or alteration (modification) to equipment (as defined in rule 567—20.2(455B)) on or before October 23, 2013, which will not result in a net emissions increase (as defined in paragraph 22.5(1)“f”) of more than 1.0 lb/hr of any regulated air pollutant (as defined in rule 567—22.100(455B)). Emission reduction achieved through the installation of control equipment, for which a construction permit has not been obtained, does not establish a limit to potential emissions.

Hazardous air pollutants (as defined in rule 567—22.100(455B)) are not included in this exemption except for those listed in Table 1. Further, the net emissions rate INCREASE must not equal or exceed the values listed in Table 1.

Table 1

Pollutant	Ton/year
Lead	0.6
Asbestos	0.007
Beryllium	0.0004
Vinyl Chloride	1
Fluorides	3

This exemption is ONLY applicable to vertical discharges with the exhaust stack height 10 or more feet above the highest building within 50 feet. If a construction permit has been previously issued for the equipment or control equipment, the conditions of the construction permit remain in effect. In order to use this exemption, the facility must comply with the information submission to the department as described above.

The department reserves the right to require proof that the expected emissions from the source which is being exempted from the air quality construction permit requirement, in conjunction with all other emissions, will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28. If the department finds, at any time after a change has been made pursuant to this exemption, evidence of violations of any of the department's rules, the department may require the source to submit to the department sufficient information to determine whether enforcement action should be taken. This information may include, but is not limited to, any information that would have been submitted in an application for a construction permit for any changes made by the source under this exemption, and air quality dispersion modeling.

Equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall not qualify for this exemption.

*j.* Residential heaters, cookstoves, or fireplaces, which burn untreated wood, untreated seeds or pellets, or other untreated vegetative materials.

*k.* Asbestos demolition and renovation projects subject to 40 CFR 61.145 as amended through January 16, 1991.

*l.* The equipment in laboratories used exclusively for nonproduction chemical and physical analyses. Nonproduction analyses means analyses incidental to the production of a good or service and includes analyses conducted for quality assurance or quality control activities, or for the assessment of environmental impact.

*m.* Storage tanks with a capacity of less than 19,812 gallons and an annual throughput of less than 200,000 gallons.

*n.* Stack or vents to prevent escape of sewer gases through plumbing traps. Systems which include any industrial waste are not exempt.

*o.* A nonproduction surface coating process that uses only hand-held aerosol spray cans.

*p.* Brazing, soldering or welding equipment or portable cutting torches used only for nonproduction activities.

*q.* Cooling and ventilating equipment: Comfort air conditioning not designed or used to remove air contaminants generated by, or released from, specific units of equipment.

*r.* An internal combustion engine with a brake horsepower rating of less than 400 measured at the shaft, provided that the owner or operator meets all of the conditions in this paragraph. For the purposes of this exemption, the manufacturer's nameplate rated capacity at full load shall be defined as the brake horsepower output at the shaft. The owner or operator of an engine that was manufactured, ordered, modified or reconstructed after March 18, 2009, may use this exemption only if the owner or operator, prior to installing, modifying or reconstructing the engine, submits to the department a

completed registration, on forms provided by the department, certifying that the engine is in compliance with the following federal regulations:

- (1) New source performance standards (NSPS) for stationary compression ignition internal combustion engines (40 CFR Part 60, Subpart IIII); or
- (2) New source performance standards (NSPS) for stationary spark ignition internal combustion engines (40 CFR Part 60, Subpart JJJJ); and
- (3) National emission standards for hazardous air pollutants (NESHAP) for reciprocating internal combustion engines (40 CFR Part 63, Subpart ZZZZ).

Use of this exemption does not relieve an owner or operator from any obligation to comply with NSPS or NESHAP requirements.

s. Equipment that is not related to the production of goods or services and used exclusively for academic purposes, located at educational institutions (as defined in Iowa Code section 455B.161). The equipment covered under this exemption is limited to: lab hoods, art class equipment, wood shop equipment in classrooms, wood fired pottery kilns, and fuel-burning units with a capacity of less than one million Btu per hour fuel capacity. This exemption does not apply to incinerators.

t. Any container, storage tank, or vessel that contains a fluid having a maximum true vapor pressure of less than 0.75 psia. "Maximum true vapor pressure" means the equilibrium partial pressure of the material considering:

- For material stored at ambient temperature, the maximum monthly average temperature as reported by the National Weather Service, or
- For material stored above or below the ambient temperature, the temperature equal to the highest calendar-month average of the material storage temperature.

u. Equipment for carving, cutting, routing, turning, drilling, machining, sawing, surface grinding, sanding, planing, buffing, sandblast cleaning, shot blasting, shot peening, or polishing ceramic artwork, leather, metals (other than beryllium), plastics, concrete, rubber, paper stock, and wood or wood products, where such equipment is either used for nonproduction activities or exhausted inside a building.

v. Manually operated equipment, as defined in rule 567—22.100(455B), used for buffing, polishing, carving, cutting, drilling, machining, routing, sanding, sawing, scarfing, surface grinding, or turning.

w. Small unit exemption.

(1) "Small unit" means any emission unit and associated control (if applicable) that emits less than the following:

1. 2 pounds per year of lead and lead compounds expressed as lead (40 pounds per year of lead or lead compounds for equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013);

2. 5 tons per year of sulfur dioxide;

3. 5 tons per year of nitrogen oxides;

4. 5 tons per year of volatile organic compounds;

5. 5 tons per year of carbon monoxide;

6. 5 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp));

7. 2.5 tons per year of PM<sub>10</sub>;

8. 0.52 tons per year of PM<sub>2.5</sub> (does not apply to equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013); or

9. 5 tons per year of hazardous air pollutants (as defined in rule 567—22.100(455B)).

For the purposes of this exemption, "emission unit" means any part or activity of a stationary source that emits or has the potential to emit any pollutant subject to regulation under the Act. This exemption applies to existing and new or modified "small units."

An emission unit that emits hazardous air pollutants (as defined in rule 567—22.100(455B)) is not eligible for this exemption if the emission unit is required to be reviewed for compliance with 567—subrule 23.1(3), emission standards for hazardous air pollutants (40 CFR 61, NESHAP), or

567—subrule 23.1(4), emission standards for hazardous air pollutants for source categories (40 CFR 63, NESHAP).

An emission unit that emits air pollutants that are not regulated air pollutants as defined in rule 567—22.100(455B) shall not be eligible to use this exemption.

(2) Permit requested. If requested in writing by the owner or operator of a small unit, the director may issue a construction permit for the emission point associated with that emission unit.

(3) An owner or operator that utilizes the small unit exemption must maintain on site an “exemption justification document.” The exemption justification document must document conformance and compliance with the emission rate limits contained in the definition of “small unit” for the particular emission unit or group of similar emission units obtaining the exemption. Controls which may be part of the exemption justification document include, but are not limited to, the following: emission control devices, such as cyclones, filters, or baghouses; restricted hours of operation or fuel; and raw material or solvent substitution. The exemption justification document for an emission unit or group of similar emission units must be made available for review during normal business hours and for state or EPA on-site inspections, and shall be provided to the director or the director’s representative upon request. If an exemption justification document does not exist, the applicability of the small unit exemption is voided for that particular emission unit or group of similar emission units. The controls described in the exemption justification document establish a limit on the potential emissions. An exemption justification document shall include the following for each applicable emission unit or group of similar emission units:

1. A narrative description of how the emissions from the emission unit or group of similar emission units were determined and maintained at or below the annual small unit exemption levels.

2. If air pollution control equipment is used, a description of the air pollution control equipment used on the emission unit or group of similar emission units and a statement that the emission unit or group of similar emission units will not be operated without the pollution control equipment operating.

3. If air pollution control equipment is used, applicant shall maintain a copy of any report of manufacturer’s testing results of any emissions test, if available. The department may require a test if it believes that a test is necessary for the exemption claim.

4. A description of all production limits required for the emission unit or group of similar emission units to comply with the exemption levels.

5. Detailed calculations of emissions reflecting the use of any air pollution control devices or production or throughput limitations, or both, for applicable emission unit or group of similar emission units.

6. Records of actual operation that demonstrate that the annual emissions from the emission unit or group of similar emission units were maintained below the exemption levels.

7. Facilities designated as major sources with respect to rules 567—22.4(455B) and 567—22.101(455B), or subject to any applicable federal requirements, shall retain all records demonstrating compliance with the exemption justification document for five years. The record retention requirements supersede any retention conditions of an individual exemption.

8. A certification from the responsible official that the emission unit or group of similar emission units have complied with the exemption levels specified in 22.1(2) “w”(1).

(4) Requirement to apply for a construction permit. An owner or operator of a small unit will be required to obtain a construction permit or take the unit out of service if the emission unit exceeds the small unit emission levels.

1. If, during an inspection or other investigation of a facility, the department believes that the emission unit exceeds the emission levels that define a “small unit,” then the department will submit calculations and detailed information in a letter to the owner or operator. The owner or operator shall have 60 days to respond with detailed calculations and information to substantiate a claim that the small unit does not exceed the emission levels that define a small unit.

2. If the owner or operator is unable to substantiate a claim to the satisfaction of the department, then the owner or operator that has been using the small unit exemption must cease operation of that small unit or apply for a construction permit for that unit within 90 days after receiving a letter of notice from

the department. The emission unit and control equipment may continue operation during this period and the associated initial application review period.

3. If the notification of nonqualification as a small unit is made by the department following the process described above, the owner or operator will be deemed to have constructed an emission unit without the required permit and may be subject to applicable penalties.

(5) Required notice for construction or modification of a “substantial small unit.” The owner or operator shall notify the department in writing at least 10 days prior to commencing construction of any new or modified “substantial small unit” as defined in 22.1(2) “w”(6). The owner or operator shall notify the department within 30 days after determining an existing small unit meets the criteria of the “substantial small unit” as defined in 22.1(2) “w”(6). Notification shall include the name of the business, the location where the unit will be installed, and information describing the unit and quantifying its emissions. The owner or operator shall notify the department within 90 days of the end of the calendar year for which the aggregate emissions from substantial small units at the facility have reached any of the cumulative notice thresholds listed below.

(6) For the purposes of this paragraph, “substantial small unit” means a small unit which emits more than the following amounts, as documented in the exemption justification document:

1. 2 pounds per year of lead and lead compounds expressed as lead (30 pounds per year of lead or lead compounds for equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013);

2. 3.75 tons per year of sulfur dioxide;

3. 3.75 tons per year of nitrogen oxides;

4. 3.75 tons per year of volatile organic compounds;

5. 3.75 tons per year of carbon monoxide;

6. 3.75 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp));

7. 1.875 tons per year of PM<sub>10</sub>;

8. 0.4 tons per year of PM<sub>2.5</sub> (does not apply to equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013); or

9. 3.75 tons per year of any hazardous air pollutant or 3.75 tons per year of any combination of hazardous air pollutants.

An emission unit is a “substantial small unit” only for those substances for which annual emissions exceed the above-indicated amounts.

(7) Required notice that a cumulative notice threshold has been reached. Once a “cumulative notice threshold,” as defined in 22.1(2) “w”(8), has been reached for any of the listed pollutants, the owner or operator at the facility must apply for air construction permits for all substantial small units for which the cumulative notice threshold for the pollutant(s) in question has been reached. The owner or operator shall have 90 days from the date it determines that the cumulative notice threshold has been reached in which to apply for construction permit(s). The owner or operator shall submit a letter to the department, within 5 working days of making this determination, establishing the date the owner or operator determined that the cumulative notice threshold had been reached.

(8) “Cumulative notice threshold” means the total combined emissions from all substantial small units using the small unit exemption which emit at the facility the following amounts, as documented in the exemption justification document:

1. 0.6 tons per year of lead and lead compounds expressed as lead;

2. 40 tons per year of sulfur dioxide;

3. 40 tons per year of nitrogen oxides;

4. 40 tons per year of volatile organic compounds;

5. 100 tons per year of carbon monoxide;

6. 25 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp));

7. 15 tons per year of PM<sub>10</sub>;

8. 10 tons per year of PM<sub>2.5</sub> (does not apply to equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013); or

9. 10 tons per year of any hazardous air pollutant or 25 tons per year of any combination of hazardous air pollutants.

x. The following equipment, processes, and activities:

(1) Cafeterias, kitchens, and other facilities used for preparing food or beverages primarily for consumption at the source.

(2) Consumer use of office equipment and products, not including printers or businesses primarily involved in photographic reproduction.

(3) Janitorial services and consumer use of janitorial products.

(4) Internal combustion engines used for lawn care, landscaping, and groundskeeping purposes.

(5) Laundry activities located at a stationary source that uses washers and dryers to clean, with water solutions of bleach or detergents, or to dry clothing, bedding, and other fabric items used on site. This exemption does not include laundry activities that use dry cleaning equipment or steam boilers.

(6) Bathroom vent emissions, including toilet vent emissions.

(7) Blacksmith forges.

(8) Plant maintenance and upkeep activities and repair or maintenance shop activities (e.g., groundskeeping, general repairs, cleaning, painting, welding, plumbing, retarring roofs, installing insulation, and paving parking lots), provided that these activities are not conducted as part of manufacturing process, are not related to the source's primary business activity, and do not otherwise trigger a permit modification. Cleaning and painting activities qualify if they are not subject to control requirements for volatile organic compounds or hazardous air pollutants as defined in rule 567—22.100(455B).

(9) Air compressors and vacuum, pumps, including hand tools.

(10) Batteries and battery charging stations, except at battery manufacturing plants.

(11) Equipment used to store, mix, pump, handle or package soaps, detergents, surfactants, waxes, glycerin, vegetable oils, greases, animal fats, sweetener, corn syrup, and aqueous salt or caustic solutions, provided that appropriate lids and covers are utilized and that no organic solvent has been mixed with such materials.

(12) Equipment used exclusively to slaughter animals, but not including other equipment at slaughterhouses, such as rendering cookers, boilers, heating plants, incinerators, and electrical power generating equipment.

(13) Vents from continuous emissions monitors and other analyzers.

(14) Natural gas pressure regulator vents, excluding venting at oil and gas production facilities.

(15) Equipment used by surface coating operations that apply the coating by brush, roller, or dipping, except equipment that emits volatile organic compounds or hazardous air pollutants as defined in rule 567—22.100(455B).

(16) Hydraulic and hydrostatic testing equipment.

(17) Environmental chambers not using gases which are hazardous air pollutants as defined in rule 567—22.100(455B).

(18) Shock chambers, humidity chambers, and solar simulators.

(19) Fugitive dust emissions related to movement of passenger vehicles on unpaved road surfaces, provided that the emissions are not counted for applicability purposes and that any fugitive dust control plan or its equivalent is submitted as required by the department.

(20) Process water filtration systems and demineralizers, demineralized water tanks, and demineralizer vents.

(21) Boiler water treatment operations, not including cooling towers or lime silos.

(22) Oxygen scavenging (deaeration) of water.

(23) Fire suppression systems.

(24) Emergency road flares.

(25) Steam vents, safety relief valves, and steam leaks.

(26) Steam sterilizers.

(27) Application of hot melt adhesives from closed-pot systems using polyolefin compounds, polyamides, acrylics, ethylene vinyl acetate and urethane material when stored and applied at the manufacturer's recommended temperatures. Equipment used to apply hot melt adhesives shall have a safety device that automatically shuts down the equipment if the hot melt temperature exceeds the manufacturer's recommended application temperature.

y. Direct-fired equipment burning natural gas, propane, or liquefied propane with a capacity of less than 10 million Btu per hour input, and direct-fired equipment burning fuel oil with a capacity of less than 1 million Btu per hour input, with emissions that are attributable only to the products of combustion. Emissions other than those attributable to the products of combustion shall be accounted for in an enforceable permit condition or shall otherwise be exempt under this subrule.

z. Closed refrigeration systems, including storage tanks used in refrigeration systems, but excluding any combustion equipment associated with such systems.

aa. Pretreatment application processes that use aqueous-based chemistries designed to clean a substrate, provided that the chemical concentrate contains no more than 5 percent organic solvents by weight. This exemption includes pretreatment processes that use aqueous-based cleaners, cleaner-phosphatizers, and phosphate conversion coating chemistries.

bb. Indoor-vented powder coating operations with filters or powder recovery systems.

cc. Electric curing ovens or curing ovens that run on natural gas or propane with a maximum heat input of less than 10 million Btu per hour and that are used for powder coating operations, provided that the total cured powder usage is less than 75 tons of powder per year at the stationary source. Records shall be maintained on site by the owner or operator for a period of at least two calendar years to demonstrate that cured powder usage is less than the exemption threshold.

dd. Each production painting, adhesive or coating unit using an application method other than a spray system and associated cleaning operations that use 1,000 gallons or less of coating and solvents annually, unless the production painting, adhesive or coating unit and associated cleaning operations are subject to work practice, process limits, emissions limits, stack testing, record-keeping or reporting requirements under 567—subrule 23.1(2), 567—subrule 23.1(3), or 567—subrule 23.1(4). Records shall be maintained on site by the owner or operator for a period of at least two calendar years to demonstrate that paint, adhesive, or solvent usage is at or below the exemption threshold.

ee. Any production surface coating activity that uses only nonrefillable hand-held aerosol cans, where the total volatile organic compound emissions from all these activities at a stationary source do not exceed 5.0 tons per year.

ff. Production welding.

(1) Consumable electrode.

1. Welding operations for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013, using a consumable electrode, provided that the consumable electrode used falls within American Welding Society specification A5.18/A5.18M for Gas Metal Arc Welding (GMAW), A5.1 or A5.5 for Shielded Metal Arc Welding (SMAW), and A5.20 for Flux Core Arc Welding (FCAW), and provided that the quantity of all electrodes used at the stationary source of the acceptable specifications is below 200,000 pounds per year for GMAW and 28,000 pounds per year for SMAW or FCAW. Records that identify the type and annual amount of welding electrode used shall be maintained on site by the owner or operator for a period of at least two calendar years. For stationary sources where electrode usage exceeds these levels, the welding activity at the stationary source may be exempted if the amount of electrode used (Y) is less than:

Y = the greater of  $1380x - 19,200$  or 200,000 for GMAW, or

Y = the greater of  $187x - 2,600$  or 28,000 for SMAW or FCAW

Where "x" is the minimum distance to the property line in feet and "Y" is the annual electrode usage in pounds per year.

If the stationary source has welding processes that fit into both of the specified exemptions, the most stringent limits must be applied.

2. Welding operations for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, using a consumable electrode, provided that the consumable electrode used falls within American Welding Society specification A5.18/A5.18M for Gas Metal Arc Welding (GMAW), A5.1 or A5.5 for Shielded Metal Arc Welding (SMAW), and A5.20 for Flux Core Arc Welding (FCAW), and provided that the quantity of all electrodes used at the stationary source of the acceptable specifications is below 1,600 pounds per year for GMAW and 12,500 pounds per year for SMAW or FCAW. Records that identify the type and annual amount of welding electrode used shall be maintained on site by the owner or operator for a period of at least two calendar years. For stationary sources where electrode usage exceeds these levels, the welding activity at the stationary source may be exempted if the amount of electrode used (Y) is less than:

Y = the greater of  $84x - 1,200$  or 1,600 for GMAW, or

Y = the greater of  $11x - 160$  or 12,500 for SMAW or FCAW

Where “x” is the minimum distance to the property line in feet and “Y” is the annual electrode usage in pounds per year.

If the stationary source has welding processes that fit into both of the specified exemptions, the most stringent limits must be applied.

(2) Resistance welding, submerged arc welding, or arc welding that does not use a consumable electrode, provided that the base metals do not include stainless steel, alloys of lead, alloys of arsenic, or alloys of beryllium and provided that the base metals are uncoated, excluding manufacturing process lubricants.

*gg.* Electric hand soldering, wave soldering, and electric solder paste reflow ovens for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013. Electric hand soldering, wave soldering, and electric solder paste reflow ovens for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall be limited to 37,000 pounds or less per year of lead-containing solder. Records shall be maintained on site by the owner or operator for at least two calendar years to demonstrate that use of lead-containing solder is less than the exemption thresholds.

*hh.* Pressurized piping and storage systems for natural gas, propane, liquefied petroleum gas (LPG), and refrigerants, where emissions could only result from an upset condition.

*ii.* Emissions from the storage and mixing of paints and solvents associated with the painting operations, provided that the emissions from the storage and mixing are accounted for in an enforceable permit condition or are otherwise exempt.

*jj.* Product labeling using laser and ink-jet printers with target distances less than or equal to six inches and an annual material throughput of less than 1,000 gallons per year as calculated on a stationary sourcewide basis.

*kk.* Equipment related to research and development activities at a stationary source, provided that:

(1) Actual emissions from all research and development activities at the stationary source based on a 12-month rolling total are less than the following levels:

2 pounds per year of lead and lead compounds expressed as lead (40 pounds per year for research and development activities that commenced on or before October 23, 2013);

5 tons per year of sulfur dioxide;

5 tons per year of nitrogen oxides;

5 tons per year of volatile organic compounds;

5 tons per year of carbon monoxide;

5 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp) as amended through November 29, 2004);

2.5 tons per year of  $PM_{10}$ ;

0.52 tons per year of  $PM_{2.5}$  (does not apply to research and development activities that commenced on or before October 23, 2013); and

5 tons per year of hazardous pollutants (as defined in rule 567—22.100(455B)); and

(2) The owner or operator maintains records of actual operations demonstrating that the annual emissions from all research and development activities conducted under this exemption are below the levels listed in subparagraph (1) above. These records shall:

1. Include a list of equipment that is included under the exemption;
2. Include records of actual operation and detailed calculations of actual annual emissions, reflecting the use of any control equipment and demonstrating that the emissions are below the levels specified in the exemption;
3. Include, if air pollution equipment is used in the calculation of emissions, a copy of any report of manufacturer's testing, if available. The department may require a test if it believes that a test is necessary for the exemption claim; and
4. Be maintained on site for a minimum of two years, be made available for review during normal business hours and for state and EPA on-site inspections, and be provided to the director or the director's designee upon request. Facilities designated as major sources pursuant to rules 567—22.4(455B) and 567—22.101(455B), or subject to any applicable federal requirements, shall retain all records demonstrating compliance with this exemption for five years.

(3) An owner or operator using this exemption obtains a construction permit or ceases operation of equipment if operation of the equipment would cause the emission levels listed in this exemption to be exceeded.

For the purposes of this exemption, "research and development activities" shall be defined as activities:

1. That are operated under the close supervision of technically trained personnel; and
2. That are conducted for the primary purpose of theoretical research or research and development into new or improved processes and products; and
3. That do not manufacture more than de minimis amounts of commercial products; and
4. That do not contribute to the manufacture of commercial products by collocated sources in more than a de minimis manner.

*ll.* A regional collection center (RCC), as defined in 567—Chapter 211, involved in the processing of permitted hazardous materials from households and conditionally exempt small quantity generators (CESQG), not to exceed 1,200,000 pounds of VOC containing material in a 12-month rolling period. Latex paint drying may not exceed 120,000 pounds per year on a 12-month rolling total. Other nonprocessing emission units (e.g., standby generators and waste oil heaters) shall not be eligible to use this exemption.

*mm.* Cold solvent cleaning machines that are not in-line cleaning machines, where the maximum vapor pressure of the solvents used shall not exceed 0.7 kPa (5 mmHg or 0.1 psi) at 20°C (68°F). The machine must be equipped with a tightly fitted cover or lid that shall be closed at all times except during parts entry and removal. This exemption cannot be used for cold solvent cleaning machines that use solvent containing methylene chloride (CAS # 75-09-2), perchloroethylene (CAS # 127-18-4), trichloroethylene (CAS # 79-01-6), 1,1,1-trichloroethane (CAS # 71-55-6), carbon tetrachloride (CAS # 56-23-5) or chloroform (CAS # 67-66-3), or any combination of these halogenated HAP solvents in a total concentration greater than 5 percent by weight.

*nn.* Emissions from mobile over-the-road trucks, and mobile agricultural and construction internal combustion engines that are operated only for repair or maintenance purposes at equipment repair shops or equipment dealerships, and only when the repair shops or equipment dealerships are not major sources as defined in rule 567—22.100(455B).

*oo.* A non-road diesel fueled engine, as defined in 40 CFR 1068.30 and as amended through October 8, 2008, with a brake horsepower rating of less than 1,100 at full load measured at the shaft, used to conduct periodic testing and maintenance on natural gas pipelines. For the purposes of this exemption, the manufacturer's nameplate rating shall be defined as the brake horsepower output at the shaft at full load.

(1) To qualify for the exemption, the engine must:

1. Be used for periodic testing and maintenance on natural gas pipelines outside the compressor station, which shall not exceed 330 hours in any 12-month consecutive period at a single location; or

2. Be used for periodic testing and maintenance on natural gas pipelines within the compressor station, which shall not exceed 330 hours in any 12-month consecutive period.

(2) The owner or operator shall maintain a monthly record of the number of hours the engine operated and a record of the rolling 12-month total of the number of hours the engine operated for each location outside the compressor station and within the compressor station. These records shall be maintained for two years. Records shall be made available to the department upon request.

(3) This exemption shall not apply to the replacement or substitution of engines for backup power generation at a pipeline compressor station.

**22.1(3) Construction permits.** The owner or operator of a new or modified stationary source shall apply for a construction permit. Two copies of a construction permit application for a new or modified stationary source shall be presented or mailed to Department of Natural Resources, Air Quality Bureau, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324. Alternatively, the owner or operator may apply for a construction permit for a new or modified stationary source through the electronic submittal format specified by the department. The owner or operator of any new or modified industrial anaerobic lagoon or a new or modified anaerobic lagoon for an animal feeding operation other than a small operation as defined in rule 567—65.1(455B) shall apply for a construction permit. Two copies of a construction permit application for an anaerobic lagoon shall be presented or mailed to Department of Natural Resources, Water Quality Bureau, Henry A. Wallace Building, 502 East Ninth Street, Des Moines, Iowa 50319.

*a. Regulatory applicability determinations.* If requested in writing, the director will review the design concepts of equipment and associated control equipment prior to application for a construction permit. The purpose of the review would be to determine the acceptability of the location of the equipment. If the review is requested, the requester shall supply the following information and submit a fee as required in 567—Chapter 30:

- (1) Preliminary plans and specifications of equipment and related control equipment.
- (2) The exact site location and a plot plan of the immediate area, including the distance to and height of nearby buildings and the estimated location and elevation of the emission points.
- (3) The estimated emission rates of any air contaminants which are to be considered.
- (4) The estimated exhaust gas temperature, velocity at the point of discharge, and stack diameter at the point of discharge.
- (5) An estimate of when construction would begin and when construction would be completed.

*b. Construction permit applications.* Each application for a construction permit shall be submitted to the department on the form “Air Construction Permit Application.” Final plans and specifications for the proposed equipment or related control equipment shall be submitted with the application for a permit and shall be prepared by or under the direct supervision of a professional engineer licensed in the state of Iowa in conformance with Iowa Code section 542B.1, or consistent with the provisions of Iowa Code section 542B.26 for any full-time employee of any corporation while doing work for that corporation. The application for a permit to construct shall include the following information:

- (1) A description of the equipment or control equipment covered by the application;
- (2) A scaled plot plan, including the distance and height of nearby buildings, and the location and elevation of existing and proposed emission points;
- (3) The composition of the effluent stream, both before and after any control equipment with estimates of emission rates, concentration, volume and temperature;
- (4) The physical and chemical characteristics of the air contaminants;
- (5) The proposed dates and description of any tests to be made by the owner or operator of the completed installation to verify compliance with applicable emission limits or standards of performance;
- (6) Information pertaining to sampling port locations, scaffolding, power sources for operation of appropriate sampling instruments, and pertinent allied facilities for making tests to ascertain compliance;
- (7) Any additional information deemed necessary by the department to determine compliance with or applicability of rules 567—22.4(455B), 567—22.5(455B), 567—31.3(455B) and 567—33.3(455B);
- (8) Application for a case-by-case MACT determination. If the source meets the definition of construction or reconstruction of a major source of hazardous air pollutants, as defined in

paragraph 22.1(1)“b,” then the owner or operator shall submit an application for a case-by-case MACT determination, as required in 567—subparagraph 23.1(4)“b”(1), with the construction permit application. In addition to this paragraph, an application for a case-by-case MACT determination shall include the following information:

1. The hazardous air pollutants (HAP) emitted by the constructed or reconstructed major source, and the estimated emission rate for each HAP, to the extent this information is needed by the permitting authority to determine MACT;

2. Any federally enforceable emission limitations applicable to the constructed or reconstructed major source;

3. The maximum and expected utilization of capacity of the constructed or reconstructed major source, and the associated uncontrolled emission rates for that source, to the extent this information is needed by the permitting authority to determine MACT;

4. The controlled emissions for the constructed or reconstructed major source in tons/yr at expected and maximum utilization of capacity to the extent this information is needed by the permitting authority to determine MACT;

5. A recommended emission limitation for the constructed or reconstructed major source consistent with the principles set forth in 40 CFR Part 63.43(d) as amended through December 27, 1996;

6. The selected control technology to meet the recommended MACT emission limitation, including technical information on the design, operation, size, estimated control efficiency of the control technology (and the manufacturer’s name, address, telephone number, and relevant specifications and drawings, if requested by the permitting authority);

7. Supporting documentation including identification of alternative control technologies considered by the applicant to meet the emission limitation, and analysis of cost and non-air quality health environmental impacts or energy requirements for the selected control technology;

8. An identification of any listed source category or categories in which the major source is included;

- (9) A signed statement that ensures the applicant’s legal entitlement to install and operate equipment covered by the permit application on the property identified in the permit application. A signed statement shall not be required for rock crushers, portable concrete or asphalt equipment used in conjunction with specific identified construction projects which are intended to be located at a site only for the duration of the specific, identified construction project; and

- (10) Application fee.

1. The owner or operator shall submit a fee as required in 567—Chapter 30 to obtain a permit under subrule 22.1(1), rule 567—22.4(455B), rule 567—22.5(455B), rule 567—22.8(455B), rule 567—22.10(455B), 567—Chapter 31 or 567—Chapter 33.

2. For application submittals from a minor source as defined in 567—Chapter 30, the department shall not initiate review and processing of a permit application submittal until all required application fees have been paid to the department.

*c. Application requirements for anaerobic lagoons.* The application for a permit to construct an anaerobic lagoon shall include the following information:

- (1) The source of the water being discharged to the lagoon;

- (2) A plot plan, including distances to nearby residences or occupied buildings, local land use zoning maps of the vicinity, and a general description of the topography in the vicinity of the lagoon;

- (3) In the case of an animal feeding operation, the information required in rule 567—65.15(455B);

- (4) In the case of an industrial source, a chemical description of the waste being discharged to the lagoon;

- (5) A report of sulfate analyses conducted on the water to be used for any purpose in a livestock operation proposing to use an anaerobic lagoon. The report shall be prepared by using standard methods as defined in 567—60.2(455B);

- (6) A description of available water supplies to prove that adequate water is available for dilution;

- (7) In the case of an animal feeding operation, a waste management plan describing the method of waste collection and disposal and the land to be used for disposal. Evidence that the waste disposal

equipment is of sufficient size to dispose of the wastes within a 20-day period per year shall also be provided;

(8) Any additional information needed by the department to determine compliance with these rules.

**22.1(4) Conditional permits.** Rescinded IAB 3/18/15, effective 4/22/15.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 7565B, IAB 2/11/09, effective 3/18/09; ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 1013C, IAB 9/18/13, effective 10/23/13; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.2(455B) Processing permit applications.**

**22.2(1) Incomplete applications.** The department will notify the applicant whether the application is complete or incomplete. If the application is found by the department to be incomplete upon receipt, the applicant will be notified within 30 days of that fact and of the specific deficiencies. Sixty days following such notification, the application may be denied for lack of information. When this schedule would cause undue hardship to an applicant, or the applicant has a compelling need to proceed promptly with the proposed installation, modification or location, a request for priority consideration and the justification therefor shall be submitted to the department.

**22.2(2) Public notice and participation.** A notice of intent to issue a construction permit to a major stationary source shall be published by the department in a newspaper having general circulation in the area affected by the emissions of the proposed source. The notice and supporting documentation shall be made available for public inspection upon request from the department's central office. Publication of the notice shall be made at least 30 days prior to issuing a permit and shall include the department's evaluation of ambient air impacts. The public may submit written comments or request a public hearing. If the response indicates significant interest, a public hearing may be held after due notice.

**22.2(3) Final notice.** The department shall notify the applicant in writing of the issuance or denial of a construction permit as soon as practicable and at least within 120 days of receipt of the completed application. This shall not apply to applicants for electric generating facilities subject to Iowa Code chapter 476A.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 1913C, IAB 3/18/15, effective 4/22/15]

**567—22.3(455B) Issuing permits.**

**22.3(1) Stationary sources other than anaerobic lagoons.** In no case shall a construction permit which results in an increase in emissions be issued to any facility which is in violation of any condition found in a permit involving PSD, NSPS, NESHAP or a provision of the Iowa state implementation plan. If the facility is in compliance with a schedule for correcting the violation and that schedule is contained in an order or permit condition, the department may consider issuance of a construction permit. A construction permit shall be issued when the director concludes that the preceding requirement has been met and:

a. That the required plans and specifications represent equipment which reasonably can be expected to comply with all applicable emission standards, and

b. That the expected emissions from the proposed source or modification in conjunction with all other emissions will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28, and

c. That the applicant has not relied on emission limits based on stack height that exceeds good engineering practice or any other dispersion techniques as defined in 567—subrule 23.1(6), and

d. That the applicant has met all other applicable requirements.

**22.3(2) Anaerobic lagoons.** A construction permit for an industrial anaerobic lagoon shall be issued when the director concludes that the application for permit represents an approach to odor control that can reasonably be expected to comply with the criteria in 567—subrule 23.5(2). A construction permit for an animal feeding operation using an anaerobic lagoon shall be issued when the director concludes that the application has met the requirements of rule 567—65.15(455B).

**22.3(3) Conditions of approval.** A permit may be issued subject to conditions which shall be specified in writing. Such conditions may include but are not limited to emission limits, operating conditions, fuel specifications, compliance testing, continuous monitoring, and excess emission reporting.

*a.* Each permit shall specify the date on which it becomes void if work on the installation for which it was issued has not been initiated.

*b.* Each permit shall list the requirements for notifying the department of the dates of intended startup, start of construction and actual equipment startup. All notifications shall be in writing and include the following information:

- (1) The date or dates required by 22.3(3) "b" for which the notice is being submitted.
- (2) Facility name.
- (3) Facility address.
- (4) DNR facility number.
- (5) DNR air construction permit number.
- (6) The name or the number of the emission unit or units in the notification.
- (7) The emission point number or numbers in the notification.
- (8) The name and signature of a company official.
- (9) The date the notification was signed.

*c.* Each permit shall specify that no review has been undertaken on the various engineering aspects of the equipment other than the potential of the equipment for reducing air contaminant emissions.

*d.* Rescinded IAB 3/18/15, effective 4/22/15.

*e.* If changes in the final plans and specifications are proposed by the permittee after a construction permit has been issued, a supplemental permit shall be obtained.

*f.* A permit is not transferable from one location to another or from one piece of equipment to another unless the equipment is portable. When portable equipment for which a permit has been issued is to be transferred from one location to another, the department shall be notified in writing at least 7 days prior to the transfer of the portable equipment to the new location. Written notification shall be submitted to the department through one of the following methods: electronic mail (e-mail), mail delivery service (including U.S. Mail), hand delivery, facsimile (fax), or by electronic format specified by the department (at such time as an Internet-based submittal system or other, similar electronic submittal system becomes available). However, if the owner or operator is relocating the portable equipment to an area currently classified as nonattainment for ambient air quality standards or to an area under a maintenance plan for ambient air quality standards, the owner or operator shall notify the department at least 14 days prior to transferring the portable equipment to the new location. A list of nonattainment and maintenance areas may be obtained from the department, upon request, or on the department's Internet Web site. The owner or operator will be notified by the department at least 10 days prior to the scheduled relocation if said relocation will prevent the attainment or maintenance of ambient air quality standards and thus require a more stringent emission standard and the installation of additional control equipment. In such a case, the owner or operator shall obtain a supplemental permit prior to the initiation of construction, installation, or alteration of such additional control equipment.

*g.* The issuance of a permit (approval to construct) shall not relieve any owner or operator of the responsibility to comply fully with applicable provisions of the state implementation plan and any other requirement under local, state or federal law.

**22.3(4) Denial of a permit.**

*a.* When an application for a construction permit is denied, the applicant shall be notified in writing of the reasons therefor. A denial shall be without prejudice to the right of the applicant to file a further application after revisions are made to meet the objections specified as reasons for the denial.

*b.* The department may deny an application based upon the applicant's failure to provide a signed statement of the applicant's legal entitlement to install and operate equipment covered by the permit application on the property identified in the permit application.

**22.3(5) Modification of a permit.** The director may, after public notice of such decision, modify a condition of approval of an existing permit for a major stationary source or an emission limit contained

in an existing permit for a major stationary source if necessary to attain or maintain an ambient air quality standard, or to mitigate excessive deposition of mercury.

**22.3(6) *Limits on hazardous air pollutants.*** The department may limit a source's hazardous air pollutant potential to emit, as defined at rule 567—22.100(455B), in the source's construction permit for the purpose of establishing federally enforceable limits on the source's hazardous air pollutant potential to emit.

**22.3(7) *Revocation of a permit.*** The department may revoke a permit upon obtaining knowledge that a permit holder has lost legal entitlement to use the property identified in the permit to install and operate equipment covered by the permit, upon notice that the property owner does not wish to have continued the operation of the permitted equipment, or upon notice that the owner of the permitted equipment no longer wishes to retain the permit for future operation.

**22.3(8) *Ownership change of permitted equipment.*** The new owner shall notify the department in writing no later than 30 days after the change in ownership of equipment covered by a construction permit pursuant to rule 567—22.1(455B). The notification to the department shall be mailed to the Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, and shall include the following information:

- a. The date of ownership change;
- b. The name, address and telephone number of the responsible official, the contact person and the owner of the equipment both before and after ownership change; and
- c. The construction permit number of the equipment changing ownership.

This rule is intended to implement Iowa Code section 455B.133

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 1913C, IAB 3/18/15, effective 4/22/15]

**567—22.4(455B) Special requirements for major stationary sources located in areas designated attainment or unclassified (PSD).** As applicable, the owner or operator of a stationary source shall comply with the rules for prevention of significant deterioration (PSD) as set forth in 567—Chapter 33. An owner or operator required to apply for a construction permit under this rule shall submit all required fees as required in 567—Chapter 30.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.5(455B) Special requirements for nonattainment areas.** As applicable, the owner or operator of a stationary source shall comply with the requirements for the nonattainment major NSR program as set forth in rule 567—31.20(455B). An owner or operator required to apply for a construction permit under this rule shall submit all required fees as required in 567—Chapter 30.

[ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.6(455B) Nonattainment area designations.** Rescinded ARC 1227C, IAB 12/11/13, effective 1/15/14.

**567—22.7(455B) Alternative emission control program.**

**22.7(1) *Applicability.*** The owner or operator of any source located in an area with attainment or unclassified status (as published at 40 CFR §81.316 amended August 5, 2013) or located in an area with an approved state implementation plan (SIP) demonstrating attainment by the statutory deadline may apply for an alternative set of emission limits if:

- a. The applicant is presently in compliance with EPA approved SIP requirements, or
- b. The applicant is subject to a consent order to meet an EPA approved compliance schedule and the final compliance date will not be delayed by the use of alternative emission limits.

**22.7(2) *Demonstration requirements.*** The applicant for the alternative emission control program shall have the burden of demonstrating that:

- a. The alternative emission control program will not interfere with the attainment and maintenance of ambient air quality standards, including the reasonable further progress or prevention of significant deterioration requirements of the Clean Air Act;

*b.* The alternative emission limits are equivalent to existing emission limits in pollution reduction, enforceability, and environmental impact; (In the case of a particulate nonattainment area, the difference between the allowable emission rate and the actual emission rate, as of January 1, 1978, cannot be credited in the emissions tradeoff.)

*c.* The pollutants being exchanged are comparable and within the same pollutant category;

*d.* Hazardous air pollutants designated in 40 CFR Part 61, as amended through July 20, 2004, will not be exchanged for nonhazardous air pollutants;

*e.* The alternative program will not result in any delay in compliance by any source.

Specific situations may require additional demonstration as specified at 44 FR 71780-71788, December 11, 1979, or as requested by the director.

**22.7(3) Approval process.**

*a.* The director shall review all alternative emission control program proposals and shall make recommendations on all completed demonstrations to the commission.

*b.* After receiving recommendations from the director and public comments made available through the hearing process, the commission may approve or disapprove the alternative emission control program proposal.

*c.* If approved by the commission, the program will be forwarded to the EPA regional administrator as a revision to the State Implementation Plan. The alternative emission control program must receive the approval of the EPA regional administrator prior to becoming effective.

[ARC 1227C, IAB 12/11/13, effective 1/15/14]

**567—22.8(455B) Permit by rule.**

**22.8(1) Permit by rule for spray booths.** Spray booths which comply with the requirements contained in this rule will be deemed to be in compliance with the requirements to obtain an air construction permit and an air operating permit. Spray booths which comply with this rule will be considered to have federally enforceable limits so that their potential emissions are less than the major source limits for regulated air pollutants and hazardous air pollutants as defined in rule 567—22.100(455B). An owner or operator required to apply for a permit by rule under this subrule shall submit fees as required in 567—Chapter 30.

*a.* Definition. “Sprayed material” is material sprayed from spray equipment when used in the surface coating process in the spray booth, including but not limited to paint, solvents, and mixtures of paint and solvents.

*b.* Facilities which facilitywide spray one gallon per day or less of sprayed material are exempt from all other requirements in 567—Chapter 22, except that they must submit the certification in 22.8(1) “e” to the department and keep records of daily sprayed material use. Any spray booth or associated equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall use sprayed material with a maximum lead content of 0.35 pounds or less per gallon if the booth or associated equipment is subject to the following NESHAP: 40 CFR Part 63, Subpart HHHHHH or Subpart XXXXXX. Any spray booth or associated equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, that is not subject to the NESHAP or is otherwise exempt from the NESHAP shall use sprayed material with a maximum lead content of 0.02 pounds or less per gallon. The owner or operator must keep the records of daily sprayed material use for 18 months from the date to which the records apply and shall keep safety data sheets (SDS) or equivalent records for at least two calendar years to demonstrate that the sprayed materials contain lead at less than the exemption thresholds. The owner or operator must also certify that the facility is in compliance with or otherwise exempt from the federal regulations specified in 22.8(1) “e.”

*c.* Facilities which facilitywide spray more than one gallon per day but never more than three gallons per day are exempt from all other requirements in 567—Chapter 22, except that they must submit the certification in 22.8(1) “e” to the department, keep records of daily sprayed material use, and vent emissions from a spray booth(s) through a stack(s) which is at least 22 feet tall, measured from ground level. Any spray booth or associated equipment for which initiation of construction,

installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall use sprayed material with a maximum lead content of 0.35 pounds or less per gallon if the booth or associated equipment is subject to the following NESHAP: 40 CFR Part 63, Subpart HHHHHH or Subpart XXXXXX. Any spray booth or associated equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, that is not subject to the NESHAP or is otherwise exempt from the NESHAP shall use sprayed material with a maximum lead content of 0.02 pounds or less per gallon. The owner or operator must keep the records of daily sprayed material use for 18 months from the date to which the records apply and shall keep safety data sheets (SDS) or equivalent records for at least two calendar years to demonstrate that the sprayed materials contain lead at less than the exemption thresholds. The owner or operator must also certify that the facility is in compliance with or otherwise exempt from the federal regulations specified in 22.8(1) “e.”

*d.* Facilities which facilitywide spray more than three gallons per day are not eligible to use the permit by rule for spray booths and must apply for a construction permit as required by subrules 22.1(1) and 22.1(3) unless otherwise exempt.

*e.* Notification letter.

(1) Facilities which claim to be permitted by provisions of this rule must submit to the department a written notification letter, on forms provided by the department, certifying that the facility meets the following conditions:

1. All paint booths and associated equipment are in compliance with the provisions of subrule 22.8(1);

2. All paint booths and associated equipment are in compliance with all applicable requirements including, but not limited to, the allowable particulate emission rate for painting and surface coating operations of 0.01 gr/scf of exhaust gas as specified in 567—subrule 23.4(13); and

3. All paint booths and associated equipment currently are or will be in compliance with or otherwise exempt from the national emissions standards for hazardous air pollutants (NESHAP) for paint stripping and miscellaneous surface coating at area sources (40 CFR Part 63, Subpart HHHHHH) and the NESHAP for metal fabricating and finishing at area sources (40 CFR Part 63, Subpart XXXXXX) by the applicable NESHAP compliance dates.

(2) The certification must be signed by one of the following individuals:

1. For corporations, a principal executive officer of at least the level of vice president, or a responsible official as defined at rule 567—22.100(455B).

2. For partnerships, a general partner.

3. For sole proprietorships, the proprietor.

4. For municipal, state, county, or other public facilities, the principal executive officer or the ranking elected official.

**22.8(2) Reserved.**

[**ARC 7565B**, IAB 2/11/09, effective 3/18/09; **ARC 8215B**, IAB 10/7/09, effective 11/11/09; **ARC 1013C**, IAB 9/18/13, effective 10/23/13; **ARC 2352C**, IAB 1/6/16, effective 12/16/15]

**567—22.9(455B) Special requirements for visibility protection.**

**22.9(1) Definitions.** Definitions included in this subrule apply to the provisions set forth in rule 567—22.9(455B).

“*Best available retrofit technology (BART)*” means an emission limitation based on the degree of reduction achievable through the application of the best system of continuous emission reduction for each pollutant which is emitted by an existing stationary facility. The emission limitation must be established, on a case-by-case basis, taking into consideration the technology available, the costs of compliance, the energy and non-air quality environmental impacts of compliance, any pollution control equipment in use or in existence at the source, the remaining useful life of the source, and the degree of improvement in visibility which may reasonably be anticipated to result from the use of such technology.

“*Deciview*” means a haze index derived from calculated light extinction, such that uniform changes in haziness correspond to uniform incremental changes in perception across the entire range

of conditions, from pristine to highly impaired. The deciview haze index is calculated based on an equation found in 40 CFR 51.301, as amended on July 1, 1999.

“Mandatory Class I area” means any Class I area listed in 40 CFR Part 81, Subpart D, as amended through October 5, 1989.

**22.9(2) Best available retrofit technology (BART) applicability.** A source shall comply with the provisions of subrule 22.9(3) if the source falls within numbers 1 through 20 or 22 through 26 of the “stationary source categories” of air pollutants listed in rule 22.100(455B) or is a fossil-fuel fired boiler individually totaling more than 250 million Btu’s per hour heat input and meets the following criteria:

- a. Any emission unit for which startup began after August 7, 1962; and
- b. Construction of the emission unit commenced on or before August 7, 1977; and
- c. The sum of the potential to emit, as “potential to emit” is defined in 567—20.2(455B), from emission units identified above is equal to or greater than 250 tons per year or more of one of the following pollutants: nitrogen oxides, sulfur dioxide, particulate matter (PM<sub>10</sub>), or volatile organic compounds.

**22.9(3) Duty to self-identify.** The owner or operator or designated representative of a facility meeting the conditions of subrule 22.9(2) shall submit two copies of a completed BART Eligibility Certification Form #542-8125, which shall include all information necessary for the department to complete eligibility determinations. The information submitted shall include source identification, description of processes, potential emissions, emission unit and emission point characteristics, date construction commenced and date of startup, and other information required by the department. The completed form was required to be submitted to the Air Quality Bureau, Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, by September 1, 2005.

**22.9(4) Notification.** The department shall notify in writing the owner or operator or designated representative of a source of the department’s determination that either:

- a. A source meets the conditions listed in 22.9(2) (a source that meets these conditions is BART-eligible); or
- b. For the purposes of the regional haze program, a source may cause or contribute to visibility impairment in any mandatory Class I area, as identified during either:
  - (1) Regional haze plan development required by 40 CFR 51.308(d) as amended on July 6, 2005; or
  - (2) A five-year periodic review on the progress toward the reasonable progress goals required by 40 CFR 51.308(g) as amended on July 6, 2005; or
  - (3) A ten-year comprehensive periodic revision of the implementation plan required by 40 CFR 51.308(f) as amended on July 6, 2005.

**22.9(5) Analysis.** The department may request in writing an analysis from the owner or operator or designated representative of a source that the department has determined may be causing or contributing to visibility impairment in a mandatory Class I area.

a. *BART control analysis.* For the purposes of BART, a source that is responsible for an impact of 1.0 deciview or more at a mandatory Class I area is considered to cause visibility impairment. A source that is responsible for an impact of 0.5 deciview or more at a mandatory Class I area is considered to contribute to visibility impairment. If a source meets either of these criteria, the owner or operator or designated representative shall prepare the BART analysis in accordance with Section IV of Appendix Y of 40 CFR Part 51 as amended through July 5, 2005, and shall submit the BART analysis 180 days after receipt of written notification by the department that a BART analysis is required.

b. *Regional haze analysis.* The owner or operator or designated representative of a source subject to 22.9(4) “b” shall prepare and submit an analysis after receipt of written notification by the department that an analysis is required.

**22.9(6) Control technology implementation.** Following the department’s review of the analysis submitted pursuant to 22.9(5), an owner or operator of a source identified in 22.9(4) shall:

- a. Submit all necessary permit applications to achieve the emissions requirements established following the completion of analysis performed in accordance with 22.9(5).
- b. Install, operate, and maintain the control technology as required by permits issued by the department.

**22.9(7) BART exemption.** The owner or operator of a source subject to the BART emission control requirements may apply for an exemption from subrule 22.9(5) in accordance with 40 CFR 51.303 as amended on July 1, 1999.

[ARC 8215B, IAB 10/7/09, effective 11/11/09]

**567—22.10(455B) Permitting requirements for country grain elevators, country grain terminal elevators, grain terminal elevators and feed mill equipment.** The requirements of this rule apply only to country grain elevators, country grain terminal elevators, grain terminal elevators and feed mill equipment, as these terms are defined in subrule 22.10(1). The requirements of this rule do not apply to equipment located at grain processing plants or grain storage elevators, as “grain processing” and “grain storage elevator” are defined in rule 567—20.2(455B). Compliance with the requirements of this rule does not alleviate any affected person’s duty to comply with any applicable state or federal regulations. In particular, the emission standards set forth in 567—Chapter 23, including the regulations for grain elevators contained in 40 CFR Part 60, Subpart DD (as adopted by reference in 567—paragraph 23.1(2) “ooo”), may apply. An owner or operator subject to this rule shall submit fees as required in 567—Chapter 30.

**22.10(1) Definitions.** For purposes of rule 567—22.10(455B), the following terms shall have the meanings indicated in this subrule.

“*Country grain elevator*” means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and which meets the following criteria:

1. Receives more than 50 percent of its grain, as “grain” is defined in this subrule, from farmers in the immediate vicinity during harvest season;
2. Is not located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant.

“*Country grain terminal elevator*” means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and which meets the following criteria:

1. Receives 50 percent or less of its grain, as “grain” is defined in this subrule, from farmers in the immediate vicinity during harvest season;
2. Has a permanent storage capacity of less than or equal to 2.5 million U.S. bushels, as “permanent storage capacity” is defined in this subrule;
3. Is not located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant.

“*Feed mill equipment*,” for purposes of rule 567—22.10(455B), means grain processing equipment that is used to make animal feed including, but not limited to, grinders, crackers, hammermills, and pellet coolers, and that is located at a country grain elevator, country grain terminal elevator or grain terminal elevator.

“*Grain*,” as set forth in Iowa Code section 203.1(9), means any grain for which the United States Department of Agriculture has established standards including, but not limited to, corn, wheat, oats, soybeans, rye, barley, grain sorghum, flaxseeds, sunflower seed, spelt (emmer), and field peas.

“*Grain processing*” shall have the same definition as “grain processing” set forth in rule 567—20.2(455B).

“*Grain storage elevator*” shall have the same definition as “grain storage elevator” set forth in rule 567—20.2(455B).

“*Grain terminal elevator*,” for purposes of rule 567—22.10(455B), means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and which meets the following criteria:

1. Receives 50 percent or less of its grain, as “grain” is defined in this subrule, from farmers in the immediate vicinity during harvest season;
2. Has a permanent storage capacity of more than 88,100 m<sup>3</sup> (2.5 million U.S. bushels), as “permanent storage capacity” is defined in this subrule;
3. Is not located at an animal food manufacturer, pet food manufacturer, cereal manufacturer, brewery, or livestock feedlot;

4. Is not located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant.

*“Permanent storage capacity”* means grain storage capacity which is inside a building, bin, or silo.

**22.10(2) Methods for determining potential to emit (PTE).** The owner or operator of a country grain elevator, country grain terminal elevator, grain terminal elevator or feed mill equipment shall use the following methods for calculating the potential to emit (PTE) for particulate matter (PM) and for particulate matter with an aerodynamic diameter less than or equal to 10 microns (PM<sub>10</sub>).

*a. Country grain elevators.* The owner or operator of a country grain elevator shall calculate the PTE for PM and PM<sub>10</sub> as specified in the definition of “potential to emit” in rule 567—20.2(455B), except that “maximum capacity” means the greatest amount of grain received at the country grain elevator during one calendar, 12-month period of the previous five calendar, 12-month periods, multiplied by an adjustment factor of 1.2. The owner or operator may make additional adjustments to the calculations for air pollution control of PM and PM<sub>10</sub> if the owner or operator submits the calculations to the department using the PTE calculation tool provided by the department, and only if the owner or operator fully implements the applicable air pollution control measures no later than March 31, 2009, or upon startup of the equipment, whichever event first occurs. Credit for the application of some best management practices, as specified in subrule 22.10(3) or in a permit issued by the department, may also be used to make additional adjustments in the PTE for PM and PM<sub>10</sub> if the owner or operator submits the calculations to the department using the PTE calculation tool provided by the department, and only if the owner or operator fully implements the applicable best management practices no later than March 31, 2009, or upon startup of the equipment, whichever event first occurs.

*b. Country grain terminal elevators.* The owner or operator of a country grain terminal elevator shall calculate the PTE for PM and PM<sub>10</sub> as specified in the definition of “potential to emit” in rule 567—20.2(455B).

*c. Grain terminal elevators.* For purposes of the permitting and other requirements specified in subrule 22.10(3), the owner or operator of a grain terminal elevator shall calculate the PTE for PM and PM<sub>10</sub> as specified in the definition of “potential to emit” in rule 567—20.2(455B). For purposes of determining whether the stationary source is subject to the prevention of significant deterioration (PSD) requirements set forth in 567—Chapter 33, or for determining whether the source is subject to the operating permit requirements set forth in rules 567—22.100(455B) through 567—22.300(455B), the owner or operator of a grain terminal elevator shall include fugitive emissions, as “fugitive emissions” is defined in 567—subrule 33.3(1) and in rule 567—22.100(455B), in the PTE calculation.

*d. Feed mill equipment.* The owner or operator of feed mill equipment, as “feed mill equipment” is defined in subrule 22.10(1), shall calculate the PTE for PM and PM<sub>10</sub> for the feed mill equipment as specified in the definition of “potential to emit” in rule 567—20.2(455B). For purposes of determining whether the stationary source is subject to the prevention of significant deterioration (PSD) requirements set forth in 567—Chapter 33, or for determining whether the stationary source is subject to the operating permit requirements set forth in rules 567—22.100(455B) through 567—22.300(455B), the owner or operator of feed mill equipment shall sum the PTE of the feed mill equipment with the PTE of the country grain elevator, country grain terminal elevator or grain terminal elevator.

**22.10(3) Classification and requirements for permits, emissions controls, record keeping and reporting for Group 1, Group 2, Group 3 and Group 4 grain elevators.** The requirements for construction permits, operating permits, emissions controls, record keeping and reporting for a stationary source that is a country grain elevator, country grain terminal elevator or grain terminal elevator are set forth in this subrule.

*a. Group 1 facilities.* A country grain elevator, country grain terminal elevator or grain terminal elevator may qualify as a Group 1 facility if the PTE at the stationary source is less than 15 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an “existing” Group 1 facility is one that commenced construction or reconstruction before February 6, 2008. A “new” Group 1 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Group 1 registration. The owner or operator of a Group 1 facility shall submit to the department a Group 1 registration, including PTE calculations, on forms provided by the department, certifying that

the facility's PTE is less than 15 tons of PM<sub>10</sub> per year. The owner or operator of an existing facility shall provide the Group 1 registration to the department on or before March 31, 2008. The owner or operator of a new facility shall provide the Group 1 registration to the department prior to initiating construction or reconstruction of a facility. The registration becomes effective upon the department's receipt of the signed registration form and the PTE calculations.

1. If the owner or operator registers with the department as specified in subparagraph 22.10(3) "a"(1), the owner or operator is exempt from the requirement to obtain a construction permit as specified under subrule 22.1(1).

2. Upon department receipt of a Group 1 registration and PTE calculations, the owner or operator is allowed to add, remove and modify the emissions units or change throughput or operations at the facility without modifying the Group 1 registration, provided that the owner or operator calculates the PTE for PM<sub>10</sub> on forms provided by the department prior to making any additions to, removals of or modifications to equipment, and only if the facility continues to meet the emissions limits and operating limits (including restrictions on material throughput and hours of operation, if applicable, as specified in the PTE for PM<sub>10</sub> calculations) specified in the Group 1 registration.

3. If equipment at a Group 1 facility currently has an air construction permit issued by the department, that permit shall remain in full force and effect, and the permit shall not be invalidated by the subsequent submittal of a registration made pursuant to subparagraph 22.10(3) "a"(1).

(2) Best management practices (BMP). The owner or operator of a Group 1 facility shall implement best management practices (BMP) for controlling air pollution at the facility and for limiting fugitive dust at the facility from crossing the property line. The owner or operator shall implement BMP according to the department manual, Best Management Practices (BMP) for Grain Elevators (December 2007; revised July 15, 2014), as adopted by the commission on January 15, 2008, and July 15, 2014, and adopted by reference herein (available from the department, upon request, and on the department's Internet Web site). No later than March 31, 2009, the owner or operator of an existing Group 1 facility shall fully implement applicable BMP, except that BMPs for grain vacuuming operations shall be fully implemented no later than September 10, 2014. Upon startup of equipment at the facility, the owner or operator of a new Group 1 facility shall fully implement applicable BMP.

(3) Record keeping. The owner or operator of a Group 1 facility shall retain a record of the previous five calendar years of total annual grain handled and shall calculate the facility's potential PM<sub>10</sub> emissions annually by January 31 for the previous calendar year. These records shall be kept on site for a period of five years and shall be made available to the department upon request.

(4) Emissions increases. The owner or operator of a Group 1 facility shall calculate any emissions increases prior to making any additions to, removals of or modifications to equipment. If the owner or operator determines that PM<sub>10</sub> emissions at a Group 1 facility will increase to 15 tons per year or more, the owner or operator shall comply with the requirements set forth for Group 2, Group 3 or Group 4 facilities, as applicable, prior to making any additions to, removals of or modifications to equipment.

(5) Changes to facility classification or permanent grain storage capacity. If the owner or operator of a Group 1 facility plans to change the facility's operations or increase the facility's permanent grain storage capacity to more than 2.5 million U.S. bushels, the owner or operator, prior to making any changes, shall reevaluate the facility's classification and the allowed method for calculating PTE to determine if any increases to the PTE for PM<sub>10</sub> will occur. If the proposed change will alter the facility's classification or will increase the facility's PTE for PM<sub>10</sub> such that the facility PTE increases to 15 tons per year or more, the owner or operator shall comply with the requirements set forth for Group 2, Group 3 or Group 4 facilities, as applicable, prior to making the change.

*b. Group 2 facilities.* A country grain elevator, country grain terminal elevator or grain terminal elevator may qualify as a Group 2 facility if the PTE at the stationary source is greater than or equal to 15 tons of PM<sub>10</sub> per year and is less than or equal to 50 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an "existing" Group 2 facility is one that commenced construction, modification or reconstruction before February 6, 2008. A "new" Group 2 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Group 2 permit for grain elevators. The owner or operator of a Group 2 facility may, in lieu of obtaining air construction permits for each piece of emissions equipment at the facility, submit to the department a completed Group 2 permit application for grain elevators, including PTE calculations, on forms provided by the department. Alternatively, the owner or operator may obtain an air construction permit as specified under subrule 22.1(1). The owner or operator of an existing facility shall provide the appropriate completed Group 2 permit application for grain elevators or the appropriate construction permit applications to the department on or before March 31, 2008. The owner or operator of a new facility shall provide the appropriate, completed Group 2 permit application for grain elevators or the appropriate construction permit applications to the department prior to initiating construction or reconstruction of a facility.

1. Upon department issuance of a Group 2 permit to a facility, the owner or operator is allowed to add, remove and modify the emissions units at the facility, or change throughput or operations, without modifying the Group 2 permit, provided that the owner or operator calculates the PTE for PM<sub>10</sub> prior to making any additions to, removals of or modifications to equipment, and only if the facility continues to meet the emissions limits and operating limits (including restrictions on material throughput and hours of operation, if applicable, as specified in the PTE for PM<sub>10</sub> calculations) specified in the Group 2 permit.

2. If a Group 2 facility currently has an air construction permit issued by the department, that permit shall remain in full force and effect, and the permit shall not be invalidated by the subsequent submittal of a Group 2 permit application for grain elevators made pursuant to this rule. However, the owner or operator of a Group 2 facility may request that the department incorporate any equipment with a previously issued construction permit into the Group 2 permit for grain elevators. The department will grant such requests on a case-by-case basis. If the department grants the request to incorporate previously permitted equipment into the Group 2 permit for grain elevators, the owner or operator of the Group 2 facility is responsible for requesting that the department rescind any previously issued construction permits.

(2) Best management practices (BMP). The owner or operator shall implement BMP, as specified in the Group 2 permit, for controlling air pollution at the source and for limiting fugitive dust at the source from crossing the property line. If the department revises the BMP requirements for Group 2 facilities after a facility is issued a Group 2 permit, the owner or operator of the Group 2 facility may request that the department modify the facility's Group 2 permit to incorporate the revised BMP requirements. The department will issue permit modifications to incorporate BMP revisions on a case-by-case basis. No later than March 31, 2009, the owner or operator of an existing Group 2 facility shall fully implement BMP, as specified in the Group 2 permit. Upon startup of equipment at the facility, the owner or operator of a new Group 2 facility shall fully implement BMP, as specified in the Group 2 permit.

(3) Record keeping. The owner or operator of a Group 2 facility shall retain all records as specified in the Group 2 permit.

(4) Emissions inventory. The owner or operator of a Group 2 facility shall submit an emissions inventory for the facility for all regulated air pollutants as specified under 567—subrule 21.1(3).

(5) Emissions increases. The owner or operator of a Group 2 facility shall calculate any emissions increases prior to making any additions to, removals of or modifications to equipment. If the owner or operator determines that potential PM<sub>10</sub> emissions at a Group 2 facility will increase to more than 50 tons per year, the owner or operator shall comply with the requirements set forth for Group 3 or Group 4 facilities, as applicable, prior to making any additions to, removals of or modifications to equipment.

(6) Changes to facility classification or permanent grain storage capacity. If the owner or operator of a Group 2 facility plans to change the facility's operations or increase the facility's permanent grain storage capacity to more than 2.5 million U.S. bushels, the owner or operator, prior to making any changes, shall reevaluate the facility's classification and the allowed method for calculating PTE to determine if any increases to the PTE for PM<sub>10</sub> will occur. If the proposed change will increase the facility's PTE for PM<sub>10</sub> such that the facility PTE increases to more than 50 tons per year, the owner or operator shall comply with the requirements set forth for Group 3 or Group 4 facilities, as applicable, prior to making the change.

*c. Group 3 facilities.* A country grain elevator, country grain terminal elevator or grain terminal elevator may qualify as a Group 3 facility if the PTE for PM<sub>10</sub> at the stationary source is greater than 50 tons per year, but is less than 100 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an “existing” Group 3 facility is one that commenced construction, modification or reconstruction before February 6, 2008. A “new” Group 3 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Air construction permit. The owner or operator of a Group 3 facility shall obtain the required construction permits as specified under subrule 22.1(1). The owner or operator of an existing facility shall provide the construction permit applications, as specified in subrule 22.1(3), to the department on or before March 31, 2008. The owner or operator of a new facility shall obtain the required permits, as specified in subrule 22.1(1), from the department prior to initiating construction or reconstruction of a facility.

(2) Permit conditions. Construction permit conditions for a Group 3 facility shall include, but are not limited to, the following:

1. The owner or operator shall implement BMP, as specified in the permit, for controlling air pollution at the source and for limiting fugitive dust at the source from crossing the property line. If the department revises the BMP requirements for Group 3 facilities after a facility is issued a permit, the owner or operator of the Group 3 facility may request that the department modify the facility’s permit to incorporate the revised BMP requirements. The department will issue permit modifications to incorporate BMP revisions on a case-by-case basis.

2. The owner or operator shall retain all records as specified in the permit.

(3) Emissions inventory. The owner or operator shall submit an emissions inventory for the facility for all regulated air pollutants as specified under 567—subrule 21.1(3).

(4) Changes to facility classification or permanent grain storage capacity. If the owner or operator of a Group 3 facility plans to change its operations or increase the facility’s permanent grain storage capacity to more than 2.5 million U.S. bushels, the owner or operator, prior to making any changes, shall reevaluate the facility’s classification and the allowed method for calculating PTE to determine if any increases to the PTE for PM<sub>10</sub> will occur. If the proposed change will alter the facility’s classification or will increase the facility’s PTE for PM<sub>10</sub> such that the facility PTE increases to greater than or equal to 100 tons per year, the owner or operator shall comply with the requirements set forth for Group 4 facilities, as applicable, prior to making the change.

(5) PSD applicability. If the PTE for PM or PM<sub>10</sub> at the Group 3 facility is greater than or equal to 250 tons per year, the owner or operator shall comply with requirements specified in 567—Chapter 33, as applicable. The owner or operator of a Group 3 facility that is a grain terminal elevator shall include fugitive emissions, as “fugitive emissions” is defined in 567—subrule 33.3(1), in the PTE calculation for determining PSD applicability.

(6) Record keeping. The owner or operator shall keep the records of annual grain handled at the facility and annual PTE for PM and PM<sub>10</sub> emissions on site for a period of five years, and the records shall be made available to the department upon request.

*d. Group 4 facilities.* A facility qualifies as a Group 4 facility if the facility is a stationary source with a PTE equal to or greater than 100 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an “existing” Group 4 facility is one that commenced construction, modification or reconstruction before February 6, 2008. A “new” Group 4 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Air construction permit. The owner or operator of a Group 4 facility shall obtain the required construction permits as specified under subrule 22.1(1). The owner or operator of an existing facility shall provide the construction permit applications, as specified by subrule 22.1(3), to the department on or before March 31, 2008. The owner or operator of a new facility shall obtain the required permits, as specified by subrule 22.1(1), from the department prior to initiating construction or reconstruction of a facility.

(2) Permit conditions. Construction permit conditions for a Group 4 facility shall include, but are not limited to, the following:

1. The owner or operator shall implement BMP, as specified in the permit, for controlling air pollution at the facility and for limiting fugitive dust at the facility from crossing the property line. If the department revises the BMP requirements for Group 4 facilities after a facility is issued a permit, the owner or operator of the Group 4 facility may request that the department modify the facility's permit to incorporate the revised BMP requirements. The department will issue permit modifications to incorporate BMP revisions on a case-by-case basis.

2. The owner or operator shall retain all records as specified in the permit.

(3) PSD applicability. If the PTE for PM or PM<sub>10</sub> at the facility is equal to or greater than 250 tons per year, the owner or operator shall comply with requirements specified in 567—Chapter 33, as applicable. The owner or operator of a Group 4 facility that is a grain terminal elevator shall include fugitive emissions, as “fugitive emissions” is defined in 567—subrule 33.3(1), in the PTE calculation for determining PSD applicability.

(4) Record keeping. The owner or operator shall keep the records of annual grain handled at the facility and annual PTE for PM and PM<sub>10</sub> emissions on site for a period of five years, and the records shall be made available to the department upon request.

(5) Operating permits. The owner or operator of a Group 4 facility shall apply for an operating permit for the facility if the facility's annual PTE for PM<sub>10</sub> is equal to or greater than 100 tons per year as specified in rules 567—22.100(455B) through 567—22.300(455B). The owner or operator of a Group 4 facility that is a grain terminal elevator shall include fugitive emissions in the calculations to determine if the PTE for PM<sub>10</sub> is greater than or equal to 100 tons per year. The owner or operator also shall submit annual emissions inventories and fees, as specified in rule 567—22.106(455B).

**22.10(4) Feed mill equipment.** This subrule sets forth the requirements for construction permits, operating permits, and emissions inventories for an owner or operator of feed mill equipment as “feed mill equipment” is defined in subrule 22.10(1). For purposes of this subrule, the owner or operator of “existing” feed mill equipment shall have commenced construction or reconstruction of the feed mill equipment before February 6, 2008. The owner or operator of “new” feed mill equipment shall have commenced construction or reconstruction of the feed mill equipment on or after February 6, 2008.

*a. Air construction permit.* The owner or operator of feed mill equipment shall obtain an air construction permit as specified under subrule 22.1(1) for each piece of feed mill equipment that emits a regulated air pollutant. The owner or operator of “existing” feed mill equipment shall provide the appropriate permit applications to the department on or before March 31, 2008. The owner or operator of “new” feed mill equipment shall provide the appropriate permit applications to the department prior to initiating construction or reconstruction of feed mill equipment.

*b. Emissions inventory.* The owner or operator shall submit an emissions inventory for the feed mill equipment for all regulated air pollutants as specified under 567—subrule 21.1(3).

*c. Operating permits.* The owner or operator shall sum the PTE of the feed mill equipment with the PTE of the equipment at the country grain elevator, country grain terminal elevator or grain terminal elevator, as PTE is specified in subrule 22.10(2), to determine if operating permit requirements specified in rules 567—22.100(455B) through 567—22.300(455B) apply to the stationary source. If the operating permit requirements apply, then the owner or operator shall apply for an operating permit as specified in rules 567—22.100(455B) through 567—22.300(455B). The owner or operator also shall begin submitting annual emissions inventories and fees, as specified under rule 567—22.106(455B).

*d. PSD applicability.* For purposes of determining whether the stationary source is subject to the prevention of significant deterioration (PSD) requirements set forth in 567—Chapter 33, the owner or operator shall sum the PTE of the feed mill equipment with the PTE of the equipment at the country grain elevator, country grain terminal elevator or grain terminal elevator. If the PTE for PM or PM<sub>10</sub> for the stationary source is equal to or greater than 250 tons per year, the owner or operator shall comply with requirements for PSD specified in 567—Chapter 33, as applicable.

[ARC 1561C, IAB 8/6/14, effective 9/10/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.11 to 22.99** Reserved.

**567—22.100(455B) Definitions for Title V operating permits.** For purposes of rules 567—22.100(455B) to 567—22.116(455B), the following terms shall have the meaning indicated in this rule:

“*Act*” means the Clean Air Act, 42 U.S.C. Sections 7401, et seq.

“*Actual emissions*” means the actual rate of emissions of a pollutant from an emissions unit, as determined in accordance with the following:

1. In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a two-year period which immediately precedes that date and which is representative of normal source operations. The director may allow the use of a different time period upon a demonstration that it is more representative of normal source operations. Actual emissions shall be calculated using the unit’s actual operating hours, production rates, and types of materials processed, stored or combusted during the selected time period. Actual emissions for acid rain affected sources are calculated using a one-year period.

2. Lacking specific information to the contrary, the director may presume that source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

3. For any emissions unit which has not begun normal operations on a particular date, actual emissions shall equal the potential to emit of the unit on that date.

4. For purposes of calculating early reductions of hazardous air pollutants, actual emissions shall not include excess emissions resulting from a malfunction or from startups and shutdowns associated with a malfunction.

Actual emissions for purposes of determining fees shall be the actual emissions calculated over a period of one year.

“*Administrator*” means the administrator for the United States Environmental Protection Agency (EPA) or designee.

“*Affected facility*” means, with reference to a stationary source, any apparatus which emits or may emit any regulated air pollutant or contaminant.

“*Affected source*” means a source that includes one or more affected units subject to any emissions reduction requirement or limitation under Title IV of the Act.

“*Affected state*” means any state which is contiguous to the permitting state and whose air quality may be affected through the modification, renewal or issuance of a Title V permit; or which is within 50 miles of the permitted source.

“*Affected unit*” means a unit that is subject to any acid rain emissions reduction requirement or acid rain emissions limitation under Title IV of the Act.

“*Allowable emissions*” means the emission rate of a stationary source calculated using both the maximum rated capacity of the source, unless the source is subject to federally enforceable limits which restrict the operating rate or hours of operation, and the most stringent of the following:

1. The applicable new source performance standards or national emissions standards for hazardous air pollutants, contained in 567—subrules 23.1(2) and 23.1(3);

2. The applicable existing source emission standard contained in 567—Chapter 23; or

3. The emissions rate specified in the air construction permit for the source.

“*Allowance*” means an authorization by the administrator under Title IV of the Act or rules promulgated thereunder to emit during or after a specified calendar year up to one ton of sulfur dioxide.

“*Applicable requirement*” includes the following:

1. Any standard or other requirement provided for in the applicable implementation plan approved or promulgated by EPA through rule making under Title I of the Act that implements the relevant requirements of the Act, including any revisions to that plan promulgated in 40 CFR 52;

2. Any term or condition of any preconstruction permits issued pursuant to regulations approved or promulgated through rule making under Title I, including Parts C and D, of the Act;

3. Any standard or other requirement under Section 111 of the Act (subrule 23.1(2)), including Section 111(d);

4. Any standard or other requirement under Section 112 of the Act, including any requirement concerning accident prevention under Section 112(r)(7) of the Act;

5. Any standard or other requirement of the acid rain program under Title IV of the Act or the regulations promulgated thereunder;
6. Any requirements established pursuant to Section 504(b) or Section 114(a)(3) of the Act;
7. Any standard or other requirement governing solid waste incineration, under Section 129 of the Act;
8. Any standard or other requirement for consumer and commercial products, under Section 183(e) of the Act;
9. Any standard or other requirement for tank vessels under Section 183(f) of the Act;
10. Any standard or other requirement of the program to control air pollution from outer continental shelf sources, under Section 328 of the Act;
11. Any standard or other requirement of the regulations promulgated to protect stratospheric ozone under Title VI of the Act, unless the administrator has determined that such requirements need not be contained in a Title V permit; and
12. Any national ambient air quality standard or increment or visibility requirement under Part C of Title I of the Act, but only as it would apply to temporary sources permitted pursuant to Section 504(e) of the Act.

“*Area source*” means any stationary source of hazardous air pollutants that is not a major source as defined in rule 567—22.100(455B).

“*CFR*” means the Code of Federal Regulations, with standard references in this chapter by Title and Part, so that “40 CFR 51” means “Title 40 of the Code of Federal Regulations, Part 51.”

“*Consumer Price Index*” means for any calendar year the average of the Consumer Price Index for all urban consumers published by the United States Department of Labor, as of the close of the 12-month period ending on August 31 of each calendar year.

“*Country grain elevator*” shall have the same definition as “country grain elevator” set forth in subrule 22.10(1).

“*Designated representative*” means a responsible natural person authorized by the owner(s) or operator(s) of an affected source and of all affected units at the source, as evidenced by a certificate of representation submitted in accordance with Subpart B of 40 CFR Part 72 as amended to October 24, 1997, to represent and legally bind each owner and operator, as a matter of federal law, in matters pertaining to the acid rain program. Whenever the term “responsible official” is used in 567—Chapter 22, it shall be deemed to refer to the designated representative with regard to all matters under the acid rain program.

“*Draft Title V permit*” means the version of a Title V permit for which the department offers public participation or affected state review.

“*Emergency generator*” means any generator of which the sole function is to provide emergency backup power during an interruption of electrical power from the electric utility. An emergency generator does not include:

1. Peaking units at electric utilities;
2. Generators at industrial facilities that typically operate at low rates, but are not confined to emergency purposes; or
3. Any standby generators that are used during time periods when power is available from the electric utility.

An emergency is an unforeseeable condition that is beyond the control of the owner or operator.

“*Emissions allowable under the permit*” means a federally enforceable permit term or condition determined at issuance to be required by an applicable requirement that establishes an emissions limit (including a work practice standard) or a federally enforceable emissions cap that the source has assumed to avoid an applicable requirement to which the source would otherwise be subject.

“*Emissions unit*” means any part or activity of a stationary source that emits or has the potential to emit any regulated air pollutant or any pollutant listed under Section 112(b) of the Act. This term is not meant to alter or affect the definition of the term “unit” for purposes of Title IV of the Act or any related regulations.

“*EPA conditional method*” means any method of sampling and analyzing for air pollutants that has been validated by the administrator but that has not been published as an EPA reference method.

“*EPA reference method*” means the following methods used for performance tests and continuous monitoring systems:

1. Performance test (stack test). A stack test shall be conducted according to EPA reference methods specified in 40 CFR 51, Appendix M (as amended through December 21, 2010); 40 CFR 60, Appendix A (as amended through September 9, 2010); 40 CFR 61, Appendix B (as amended through October 17, 2000); and 40 CFR 63, Appendix A (as amended through August 20, 2010).

2. Continuous monitoring systems. Minimum performance specifications and quality assurance procedures for performance evaluations of continuous monitoring systems are as specified in 40 CFR 60, Appendix B (as amended through September 9, 2010); 40 CFR 60, Appendix F (as amended through September 9, 2010); 40 CFR 75, Appendix A (as amended through March 28, 2011); 40 CFR 75, Appendix B (as amended through March 28, 2011); and 40 CFR 75, Appendix F (as amended through March 28, 2011).

“*Equipment leaks*” means leaks from pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, agitators, accumulator vessels, and instrumentation systems.

“*Existing hazardous air pollutant source*” means any source as defined in 40 CFR 61 (as amended through July 20, 2004) and 40 CFR 63.72 (as amended through December 29, 1992) with respect to Section 112(i)(5) of the Act, the construction or reconstruction of which commenced prior to proposal of an applicable Section 112(d) standard.

“*Facility*” means, with reference to a stationary source, any apparatus which emits or may emit any air pollutant or contaminant.

“*Federal implementation plan*” means a plan promulgated by the administrator to fill all or a portion of a gap or otherwise correct all or a portion of an inadequacy in a state implementation plan, and which includes enforceable emission limitations or other control measures, means or techniques, and provides for attainment of the relevant national ambient air quality standard.

“*Federally enforceable*” means all limitations and conditions which are enforceable by the administrator including, but not limited to, the requirements of the new source performance standards and national emission standards for hazardous air pollutants contained in 567—subrules 23.1(2) and 23.1(3); the requirements of such other state rules or orders approved by the administrator for inclusion in the SIP; and any construction, Title V or other federally approved operating permit conditions.

“*Final Title V permit*” means the version of a Title V permit issued by the department that has completed all required review procedures.

“*Fugitive emissions*” are those emissions which could not reasonably pass through a stack, chimney, vent or other functionally equivalent opening.

“*Hazardous air pollutant*” means any of the following air pollutants listed in Section 112 of the Act:

cas #	chemical name
75343	1,1-Dichloroethane
57147	1,1-Dimethyl hydrazine
71556	1,1,1-Trichloroethane
79005	1,1,2-Trichloroethane
79345	1,1,2,2-Tetrachloroethane
106887	1,2-Butylene oxide
96128	1,2-Dibromo-3-chloropropane
106934	1,2-Dibromoethane
107062	1,2-Dichloroethane
78875	1,2-Dichloropropane

cas #	chemical name
122667	1,2-Diphenylhydrazine
120821	1,2,4-Trichlorobenzene
106990	1,3-Butadiene
542756	1,3-Dichloropropylene
106467	1,4-Dichlorobenzene
123911	1,4-Dioxane
53963	2-Acetylaminofluorene
532274	2-Chloroacetophenone
79469	2-Nitropropane
540841	2,2,4-Trimethylpentane
1746016	2,3,7,8-Tetrachlorodibenzo-p-dioxin (TC-DD)
94757	2,4-D salts and esters
95807	2,4-Diaminotoluene
51285	2,4-Dinitrophenol
121142	2,4-Dinitrotoluene
95954	2,4,5-Trichlorophenol
88062	2,4,6-Trichlorophenol
91941	3,3'-Dichlorobenzidine
119904	3,3'-Dimethoxybenzidine
119937	3,3'-Dimethylbenzidine
92671	4-Aminobiphenyl
60117	4-Dimethylaminoazobenzene
92933	4-Nitrobiphenyl
100027	4-Nitrophenol
101144	4,4'-Methylenebis(2-chloroaniline)
101779	4,4'-methylenedianiline
534521	4,6-Dinitro-o-cresol, and salts
75070	Acetaldehyde
60355	Acetamide
75058	Acetonitrile
98862	Acetophenone
107028	Acrolein
79061	Acrylamide
79107	Acrylic acid
107131	Acrylonitrile
107051	Allyl chloride
62533	Aniline
0	Antimony Compounds
0	Arsenic Compounds (inorganic including arsine)
1332214	Asbestos (friable)
71432	Benzene

cas #	chemical name
92875	Benzidine
98077	Benzoic trichloride
100447	Benzyl chloride
0	Beryllium Compounds
57578	Beta-Propiolactone
92524	Biphenyl
111444	Bis(2-chloroethyl) ether
542881	Bis(chloromethyl) ether
75252	Bromoform
74839	Bromomethane
0	Cadmium Compounds
156627	Calcium cyanamide
133062	Captan
63252	Carbaryl
75150	Carbon disulfide
56235	Carbon tetrachloride
463581	Carbonyl sulfide
120809	Catechol
133904	Chloramben
57749	Chlordane
7782505	Chlorine
79118	Chloroacetic acid
108907	Chlorobenzene
510156	Chlorobenzilate
75003	Chloroethane
67663	Chloroform
74873	Chloromethane
107302	Chloromethyl methyl ether
126998	Chloroprene
0	Chromium Compounds
0	Cobalt Compounds
0	Coke Oven Emissions
1319773	Cresol/Cresylic acid (isomers & mixture)
98828	Cumene
0	Cyanide Compounds <sup>1</sup>
72559	DDE
117817	Di(2-ethylhexyl) phthalate
334883	Diazomethane
132649	Dibenzofuran
84742	Dibutyl phthalate
75092	Dichloromethane

cas #	chemical name
62737	Dichlorvos
111422	Diethanolamine
64675	Diethyl sulfate
68122	Dimethyl formamide
131113	Dimethyl phthalate
77781	Dimethyl sulfate
79447	Dimethylcarbamyl chloride
106898	Epichlorohydrin
140885	Ethyl acrylate
100414	Ethylbenzene
107211	Ethylene glycol
75218	Ethylene oxide
96457	Ethylene thiourea
151564	Ethyleneimine
0	Fine Mineral Fibers <sup>3</sup>
50000	Formaldehyde
0	Glycol Ethers <sup>2</sup> , except cas #111-76-2, ethylene glycol mono-butyl ether, also known as EGBE or 2-Butoxyethanol
76448	Heptachlor
87683	Hexachloro-1,3-butadiene
118741	Hexachlorobenzene
77474	Hexachlorocyclopentadiene
67721	Hexachloroethane
822060	Hexamethylene-1,6-diisocyanate
680319	Hexamethylphosphoramide
110543	Hexane
302012	Hydrazine
7647010	Hydrochloric acid
7664393	Hydrogen fluoride
123319	Hydroquinone
78591	Isophorone
0	Lead Compounds
58899	Lindane (all isomers)
108394	m-Cresol
108383	m-Xylene
108316	Maleic anhydride
0	Manganese Compounds
0	Mercury Compounds
67561	Methanol
72435	Methoxychlor
60344	Methyl hydrazine

cas #	chemical name
74884	Methyl iodide
108101	Methyl isobutyl ketone
624839	Methyl isocyanate
80626	Methyl methacrylate
1634044	Methyl tertbutyl ether
101688	Methylene bis(phenylisocyanate)
684935	N-Nitroso-N-methylurea
62759	N-Nitrosodimethylamine
59892	N-Nitrosomorpholine
91203	Naphthalene
0	Nickel Compounds
98953	Nitrobenzene
121697	N,N-Dimethylaniline
90040	o-Anisidine
95487	o-Cresol
95534	o-Toluidine
95476	o-Xylene
106445	p-Cresol
106503	p-Phenylenediamine
106423	p-Xylene
56382	Parathion
87865	Pentachlorophenol
108952	Phenol
75445	Phosgene
7803512	Phosphine
7723140	Phosphorus (yellow or white)
85449	Phthalic anhydride
1336363	Polychlorinated biphenyls
0	Polycyclic Organic Matter <sup>4</sup>
1120714	Propane sultone
123386	Propionaldehyde
114261	Propoxur
75569	Propylene oxide
75558	Propyleneimine
91225	Quinoline
106514	Quinone
82688	Quintozene
0	Radionuclides (including Radon) <sup>5</sup>
0	Selenium Compounds
100425	Styrene
96093	Styrene oxide

cas #	chemical name
127184	Tetrachloroethylene
7550450	Titanium tetrachloride
108883	Toluene
584849	Toluene-2,4-diisocyanate
8001352	Toxaphene
79016	Trichloroethylene
121448	Triethylamine
1582098	Trifluralin
51796	Urethane
108054	Vinyl acetate
593602	Vinyl bromide
75014	Vinyl chloride
75354	Vinylidene chloride
1330207	Xylene (mixed isomers)

NOTE: For all listings above which contain the word “compounds” and for glycol ethers, the following applies: Unless otherwise specified, these listings are defined as including any unique chemical substance that contains the named chemical (i.e., antimony, arsenic, etc.) as part of that chemical’s infrastructure.

<sup>1</sup>X’CN where X=H’ or any other group where a formal dissociation may occur. For example KCN or Ca(CN)<sub>2</sub>

<sup>2</sup>Includes mono- and di-ethers of ethylene glycol, diethylene glycol, and triethylene glycol R(OCH<sub>2</sub>CH<sub>2</sub>)<sub>n</sub>-OR’ where n=1,2, or 3; R=alkyl or aryl groups; R’=R,H, or groups which, when removed, yield glycol ethers with the structure R(OCH<sub>2</sub>CH)<sub>n</sub>-OH. Polymers are excluded from the glycol category.

<sup>3</sup>Includes mineral fiber emissions from facilities manufacturing or processing glass, rock, or slag fibers (or other mineral derived fibers) of average diameter 1 micrometer or less.

<sup>4</sup>Includes organic compounds with more than one benzene ring, and which have a boiling point greater than or equal to 100 degrees C.

<sup>5</sup>A type of atom which spontaneously undergoes radioactive decay.

“*High-risk pollutant*” means one of the following hazardous air pollutants listed in Table 1 in 40 CFR 63.74 as amended through October 21, 1994.

cas #	chemical name	weighting factor
53963	2-Acetylaminofluorene	100
107028	Acrolein	100
79061	Acrylamide	10
107131	Acrylonitrile	10
0	Arsenic compounds	100
1332214	Asbestos	100
71432	Benzene	10
92875	Benzidine	1000
0	Beryllium compounds	10
542881	Bis(chloromethyl) ether	1000
106990	1,3-Butadiene	10
0	Cadmium compounds	10

cas #	chemical name	weighting factor
57749	Chlordane	100
532274	2-Chloroacetophenone	100
0	Chromium compounds	100
107302	Chloromethyl methyl ether	10
0	Coke oven emissions	10
334883	Diazomethane	10
132649	Dibenzofuran	10
96128	1,2-Dibromo-3-chloropropane	10
111444	Dichloroethyl ether(Bis(2-chloroethyl)ether)	10
79447	Dimethylcarbamoyl chloride	100
122667	1,2-Diphenylhydrazine	10
106934	Ethylene dibromide	10
151564	Ethylenimine (Aziridine)	100
75218	Ethylene oxide	10
76448	Heptachlor	100
118741	Hexachlorobenzene	100
77474	Hexachlorocyclopentadiene	100
302012	Hydrazine	100
0	Manganese compounds	10
0	Mercury compounds	100
60344	Methyl hydrazine	10
624839	Methyl isocyanate	10
0	Nickel compounds	10
62759	N-Nitrosodimethylamine	100
684935	N-Nitroso-N-methylurea	1000
56382	Parathion	10
75445	Phosgene	10
7803512	Phosphine	10
7723140	Phosphorus	10
75558	1,2-Propylenimine	100
1746016	2,3,7,8-Tetrachlorodibenzo-p-dioxin	100,000
8001352	Toxaphene (chlorinated camphene)	100
75014	Vinyl chloride	10

“Major source” means any stationary source (or any group of stationary sources located on one or more contiguous or adjacent properties and under common control of the same person or of persons under common control) belonging to a single major industrial grouping that is any of the following:

1. A major stationary source of air pollutants, as defined in Section 302 of the Act, that directly emits or has the potential to emit 100 tons per year (tpy) or more of any air pollutant subject to regulation (including any major source of fugitive emissions of any such pollutant). The fugitive emissions of a stationary source shall not be considered in determining whether it is a major stationary source for the purposes of Section 302(j) of the Act, unless the source belongs to one of the stationary source categories listed in this chapter.

2. A major source of hazardous air pollutants according to Section 112 of the Act as follows:

For pollutants other than radionuclides, 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, in the aggregate, 10 tpy or more of any hazardous air pollutant which has been listed pursuant to Section 112(b) of the Act and these rules or 25 tpy or more of any combination of such hazardous air pollutants. Notwithstanding the previous sentence, emissions from any oil or gas exploration or production well (with its associated equipment) and emission from any pipeline compressor or pump station shall not be aggregated with emissions from other similar units, whether or not such units are in a contiguous area or under common control, to determine whether such units or stations are major sources.

For Title V purposes, all fugitive emissions of hazardous air pollutants are to be considered in determining whether a stationary source is a major source.

For radionuclides, "major source" shall have the meaning specified by the administrator by rule.

3. A major stationary source as defined in Part D of Title I of the Act, including:

For ozone nonattainment areas, sources with the potential to emit 100 tpy or more of volatile organic compounds or oxides of nitrogen in areas classified as "marginal" or "moderate," 50 tpy or more in areas classified as "serious," 25 tpy or more in areas classified as "severe" and 10 tpy or more in areas classified as "extreme"; except that the references in this paragraph to 100, 50, 25, and 10 tpy of nitrogen oxides shall not apply with respect to any source for which the administrator has made a finding, under Section 182(f)(1) or (2) of the Act, that requirements under Section 182(f) of the Act do not apply;

For ozone transport regions established pursuant to Section 184 of the Act, sources with potential to emit 50 tpy or more of volatile organic compounds;

For carbon monoxide nonattainment areas (1) that are classified as "serious" and (2) in which stationary sources contribute significantly to carbon monoxide levels, and sources with the potential to emit 50 tpy or more of carbon monoxide;

For particulate matter (PM-10), nonattainment areas classified as "serious," sources with the potential to emit 70 tpy or more of PM-10.

For the purposes of defining "major source," a stationary source or group of stationary sources shall be considered part of a single industrial grouping if all of the pollutant emitting activities at such source or group of sources on contiguous or adjacent properties belong to the same major group (i.e., all have the same two-digit code) as described in the Standard Industrial Classification Manual, 1987.

*"Manually operated equipment"* means a machine or tool that is handheld, such as a handheld circular saw or compressed air chisel; a machine or tool for which the work piece is held or manipulated by hand, such as a bench grinder; a machine or tool for which the tool or bit is manipulated by hand, such as a lathe or drill press; and any dust collection system which is part of such machine or tool; but not including any machine or tool for which the extent of manual operation is to control power to the machine or tool and not including any central dust collection system serving more than one machine or tool.

*"Maximum achievable control technology (MACT)"* means the following regarding regulated hazardous air pollutant sources:

1. For existing sources, the emissions limitation reflecting the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any nonair quality health and environmental impacts and energy requirements, determines is achievable by sources in the category of stationary sources, that shall not be less stringent than the MACT floor.

2. For new sources, the emission limitation which is not less stringent than the emission limitation achieved in practice by the best-controlled similar source, and which reflects the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any nonair quality health and environmental impacts and energy requirements, determines is achievable by sources in the Title IV affected source category.

*"Maximum achievable control technology (MACT) floor"* means the following:

1. For existing sources, the average emission limitation achieved by the best 12 percent of the existing sources in the United States (for which the administrator or the department has or could

reasonably obtain emission information), excluding those sources that have, within 18 months before the emission standard is proposed or within 30 months before such standard is promulgated, whichever is later, first achieved a level of emission rate or emission reduction which complies, or would comply if the source is not subject to such standard, with the lowest achievable emission rate applicable to the source category and prevailing at the time, for categories and subcategories of stationary sources with 30 or more sources in the category or subcategory, or the average emission limitation achieved by the best performing 5 sources in the United States (for which the administrator or the department has or could reasonably obtain emissions information) for a category or subcategory or stationary source with fewer than 30 sources in the category or subcategory.

2. For new sources, the emission limitation achieved in practice by the best-controlled similar source.

*“New Title IV affected source or unit”* means a unit that commences commercial operation on or after November 15, 1990, including any such unit that serves a generator with a nameplate capacity of 25 MWe or less or that is a simple combustion turbine.

*“Nonattainment area”* means an area so designated by the administrator, acting pursuant to Section 107 of the Act.

*“Permit modification”* means a revision to a Title V operating permit that cannot be accomplished under the provisions for administrative permit amendments found at rule 567—22.111(455B). A permit modification for purposes of the acid rain portion of the permit shall be governed by the regulations pertaining to acid rain found at rules 567—22.120(455B) to 567—22.147(455B). This definition of “permit modification” shall be used solely for purposes of this chapter governing Title V operating permits.

*“Permit revision”* means any permit modification or administrative permit amendment.

*“Permitting authority”* means the Iowa department of natural resources or the director thereof.

*“Potential to emit”* means the maximum capacity of a stationary source to emit any air pollutant under its physical and operational design. Any physical or operational limitation on the capacity of a source to emit an air pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation is enforceable by the administrator. This term does not alter or affect the use of this term for any other purposes under the Act, or the term “capacity factor” as used in Title IV of the Act or the regulations relating to acid rain.

For the purpose of determining potential to emit for country grain elevators, the provisions set forth in subrule 22.10(2) shall apply.

For purposes of calculating potential to emit for emergency generators, “maximum capacity” means one of the following:

1. 500 hours of operation annually, if the generator has actually been operated less than 500 hours per year for the past five years;
2. 8,760 hours of operation annually, if the generator has actually been operated more than 500 hours in one of the past five years; or
3. The number of hours specified in a state or federally enforceable limit.

*“Proposed Title V permit”* means the version of a permit that the permitting authority proposes to issue and forwards to the administrator for review in compliance with 22.107(7)“a.”

*“Regulated air contaminant”* shall mean the same thing as “regulated air pollutant.”

*“Regulated air pollutant”* means the following:

1. Nitrogen oxides or any volatile organic compounds;
2. Any pollutant for which a national ambient air quality standard has been promulgated;
3. Any pollutant that is subject to any standard promulgated under Section 111 of the Act;
4. Any Class I or II substance subject to a standard promulgated under or established by Title VI of the Act; or
5. Any pollutant subject to a standard promulgated under Section 112 or other requirements established under Section 112 of the Act, including Sections 112(g), (j), and (r) of the Act, including the following:

- Any pollutant subject to requirements under Section 112(j) of the Act. If the administrator fails to promulgate a standard by the date established pursuant to Section 112(e) of the Act, any pollutant for which a subject source would be major shall be considered to be regulated on the date 18 months after the applicable date established pursuant to Section 112(e) of the Act; and

- Any pollutant for which the requirements of Section 112(g)(2) of the Act have been met, but only with respect to the individual source subject to the Section 112(g)(2) requirement.

6. With respect to Title V, particulate matter, except for PM10, is not considered a regulated air pollutant for the purpose of determining whether a source is considered to be a major source.

“*Regulated air pollutant or contaminant (for fee calculation)*,” which is used only for purposes of 567—Chapter 30, means any “regulated air pollutant or contaminant” except the following:

1. Carbon monoxide;
2. Particulate matter, excluding PM10;
3. Any pollutant that is a regulated air pollutant solely because it is a Class I or II substance subject to a standard promulgated under or established by Title VI of the Act;

4. Any pollutant that is a regulated pollutant solely because it is subject to a standard or regulation under Section 112(r) of the Act;

5. Greenhouse gas, as defined in rule 567—20.2(455B).

“*Renewal*” means the process by which a permit is reissued at the end of its term.

“*Responsible official*” means one of the following:

1. For a corporation: a president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or a duly authorized representative of such person if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a permit and either:
  - The facilities employ more than 250 persons or have gross annual sales or expenditures exceeding \$25 million (in second quarter 1980 dollars); or
  - The delegation of authority to such representative is approved in advance by the permitting authority.

2. For a partnership or sole proprietorship: a general partner or the proprietor, respectively;

3. For a municipality, state, federal, or other public agency: either a principal executive officer or ranking elected official. For the purposes of this chapter, a principal executive officer of a federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency (e.g., a regional administrator of EPA); or

4. For Title IV affected sources:

- The designated representative insofar as actions, standards, requirements, or prohibitions under Title IV of the Act or the regulations promulgated thereunder are concerned; and

- The designated representative for any other purposes under this chapter or the Act.

“*Section 502(b)(10) changes*” are changes that contravene an express permit term and which are made pursuant to rule 567—22.110(455B). Such changes do not include changes that would violate applicable requirements or contravene federally enforceable permit terms and conditions that are monitoring (including test methods), record keeping, reporting, or compliance certification requirements.

“*State implementation plan (SIP)*” means the plan adopted by the state of Iowa and approved by the administrator which provides for implementation, maintenance, and enforcement of such primary and secondary ambient air quality standards as are adopted by the administrator, pursuant to the Act.

“*Stationary source*” means any building, structure, facility, or installation that emits or may emit any regulated air pollutant or any pollutant listed under Section 112(b) of the Act.

“*Stationary source categories*” means any of the following classes of sources:

1. Coal cleaning plants with thermal dryers;
2. Kraft pulp mills;
3. Portland cement plants;
4. Primary zinc smelters;

5. Iron and steel mills;
6. Primary aluminum ore reduction plants;
7. Primary copper smelters;
8. Municipal incinerators capable of charging more than 250 tons of refuse per day;
9. Hydrofluoric, sulfuric, or nitric acid plants;
10. Petroleum refineries;
11. Lime plants;
12. Phosphate rock processing plants;
13. Coke oven batteries;
14. Sulfur recovery plants;
15. Carbon black plants using the furnace process;
16. Primary lead smelters;
17. Fuel conversion plants;
18. Sintering plants;
19. Secondary metal production plants;
20. Chemical process plants — The term chemical processing plant shall not include ethanol production facilities that produce ethanol by natural fermentation included in NAICS code 325193 or 312140;
21. Fossil-fuel boilers, or combinations thereof, totaling more than 250 million Btu's per hour heat input;
22. Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels;
23. Taconite ore processing plants;
24. Glass fiber processing plants;
25. Charcoal production plants;
26. Fossil fuel-fired steam electric plants of more than 250 million Btu's per hour heat input;
27. Any other stationary source category, which as of August 7, 1980, is regulated under Section 111 or 112 of the Act.

“*Subject to regulation*” means, for any air pollutant, that the pollutant is subject to either a provision in the Clean Air Act, or a nationally applicable regulation codified by the Administrator in 40 CFR Subchapter C (Air Programs) that requires actual control of the quantity of emissions of that pollutant, and that such a control requirement has taken effect and is operative to control, limit or restrict the quantity of emissions of that pollutant released from the regulated activity, except that:

1. Greenhouse gases (GHGs), the air pollutant defined in 40 CFR §86.1818-12(a) (as amended on May 7, 2010) as the aggregate group of six greenhouse gases that includes carbon dioxide, nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride, shall not be subject to regulation unless, as of July 1, 2011, the GHG emissions are at a stationary source emitting or having the potential to emit 100,000 tpy CO<sub>2</sub> equivalent emissions.

2. The term “tpy CO<sub>2</sub> equivalent emissions (CO<sub>2</sub>e)” shall represent an amount of GHGs emitted and shall be computed by multiplying the mass amount of emissions (tpy) for each of the six greenhouse gases in the pollutant GHGs by the associated global warming potential of the gas published at 40 CFR Part 98, Subpart A, Table A-1, “Global Warming Potentials,” (as amended on October 30, 2009) and summing the resultant value for each to compute a tpy CO<sub>2</sub>e.

For purposes of this definition, prior to July 21, 2014, the mass of the greenhouse gas carbon dioxide shall not include carbon dioxide emissions resulting from the combustion or decomposition of non-fossilized and biodegradable organic material originating from plants, animals, or micro-organisms (including products, by-products, residues and waste from agriculture, forestry and related industries as well as the non-fossilized and biodegradable organic fractions of industrial and municipal wastes, including gases and liquids recovered from the decomposition of non-fossilized and biodegradable organic material).

“*Title V permit*” means an operating permit under Title V of the Act.

“12-month rolling period” means a period of 12 consecutive months determined on a rolling basis with a new 12-month period beginning on the first day of each calendar month.

[ARC 9224B, IAB 11/17/10, effective 12/22/10; ARC 9906B, IAB 12/14/11, effective 11/16/11; ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.101(455B) Applicability of Title V operating permit requirements.**

**22.101(1)** Except as provided in rule 567—22.102(455B), any person who owns or operates any of the following sources shall obtain a Title V operating permit and shall submit fees as required in 567—Chapter 30:

- a. Any affected source subject to the provisions of Title IV of the Act;
- b. Any major source;
- c. Any source, including any nonmajor source, subject to a standard, limitation, or other requirement under Section 111 of the Act (567—subrule 23.1(2), new source performance standards; 567—subrule 23.1(5), emission guidelines);
- d. Any source, including any area source, subject to a standard or other requirement under Section 112 of the Act (567—subrules 23.1(3) and 23.1(4), emission standards for hazardous air pollutants), except that a source is not required to obtain a Title V permit solely because it is subject to regulations or requirements under Section 112(r) of the Act;
- e. Any solid waste incinerator unit required to obtain a Title V permit under Section 129(e) of the Act;
- f. Any source category designated by the Administrator pursuant to 40 CFR 70.3 as amended through December 19, 2005.

**22.101(2)** Any nonmajor source required to obtain a Title V operating permit pursuant to subrule 22.101(1) is required to obtain a Title V permit only for the emissions units and related equipment causing the source to be subject to the Title V program.

**22.101(3)** Election to apply for permit. Rescinded IAB 7/19/06, effective 8/23/06.  
[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.102(455B) Source category exemptions.**

**22.102(1)** All sources listed in subrule 22.101(1) that are not major sources, affected sources subject to the provisions of Title IV of the Act or solid waste incineration units required to obtain a permit pursuant to Section 129(e) of the Act are exempt from the obligation to obtain a Title V permit until such time as the Administrator completes a rule making to determine how the program should be structured for nonmajor sources and the appropriateness of any permanent exemptions in addition to those provided for in subrule 22.102(3).

**22.102(2)** In the case of nonmajor sources subject to a standard or other requirement under either Section 111 or Section 112 of the Act after July 21, 1992, publication, the Administrator will determine at the time the new or amended standard is promulgated whether to exempt any or all such applicable sources from the requirement to obtain a Title V permit.

**22.102(3)** The following source categories are exempt from the obligation to obtain a Title V permit:

- a. All sources and source categories that would be required to obtain a Title V permit solely because they are subject to 40 CFR 60, Subpart AAA, Standards of Performance for New Residential Wood Heaters, as amended through December 14, 2000;
- b. All sources and source categories that would be required to obtain a Title V permit solely because they are subject to 40 CFR 61, Subpart M, National Emission Standard for Hazardous Air Pollutants for Asbestos, Section 61.145, Standard for Demolition and Renovation, as amended through July 20, 2004;
- c. All sources and source categories that would be required to obtain a Title V permit solely because they are subject to any of the following subparts from 40 CFR 63:
  - (1) Subpart M, National Perchloroethylene Air Emission Standards for Dry Cleaning Facilities, as amended through December 19, 2005.
  - (2) Subpart N, National Emission Standards for Chromium Emissions from Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks, as amended through December 19, 2005.

(3) Subpart O, Ethylene Oxide Emissions Standards for Sterilization Facilities, as amended through December 19, 2005.

(4) Subpart T, National Emission Standards for Halogenated Solvent Cleaning, as amended through December 19, 2005.

(5) Subpart RRR, National Emission Standards for Hazardous Air Pollutants for Secondary Aluminum Production, as amended through December 19, 2005.

(6) Subpart VVV, National Emission Standards for Hazardous Air Pollutants: Publicly Owned Treatment Works, as amended through June 23, 2003.

**567—22.103(455B) Insignificant activities.** The following are insignificant activities for purposes of the Title V application if not needed to determine the applicability of or to impose any applicable requirement. Title V permit emissions fees are not required from insignificant activities pursuant to 567—paragraph 30.4(2)“f.”

**22.103(1) Insignificant activities excluded from Title V operating permit application.** In accordance with 40 CFR 70.5 (as amended through July 21, 1992), these activities need not be included in the Title V permit application.

- a. Mobile internal combustion and jet engines, marine vessels, and locomotives.
- b. Equipment, other than anaerobic lagoons, used for cultivating land, harvesting crops, or raising livestock. This exemption is not applicable if the equipment is used to remove substances from grain which were applied to the grain by another person. This exemption also is not applicable to equipment used by a person to manufacture commercial feed, as defined in Iowa Code section 198.3, when that feed is normally not fed to livestock:
  - (1) Owned by that person or another person, and
  - (2) Located in a feedlot, as defined in Iowa Code section 172D.1(6), or in a confinement building owned or operated by that person, and
  - (3) Located in this state.
- c. Equipment or control equipment which eliminates all emissions to the atmosphere.
- d. Equipment (other than anaerobic lagoons) or control equipment which emits odors unless such equipment or control equipment also emits particulate matter or any other air pollutant or contaminant.
- e. Air conditioning or ventilating equipment not designed to remove air contaminants generated by or released from associated equipment.
- f. Residential wood heaters, cookstoves, or fireplaces.
- g. The equipment in laboratories used exclusively for nonproduction chemical and physical analyses. Nonproduction analyses means analyses incidental to the production of a good or service and includes analyses conducted for quality assurance or quality control activities, or for the assessment of environmental impact.
- h. Recreational fireplaces.
- i. Barbecue pits and cookers except at a meat packing plant or a prepared meat manufacturing facility.
- j. Stacks or vents to prevent escape of sewer gases through plumbing traps for systems handling domestic sewage only. Systems which include any industrial waste are not exempt.
- k. Retail gasoline and diesel fuel handling facilities.
- l. Photographic process equipment by which an image is reproduced upon material sensitized to radiant energy.
- m. Equipment used for hydraulic or hydrostatic testing.
- n. General vehicle maintenance and servicing activities at the source, other than gasoline fuel handling.
- o. Cafeterias, kitchens, and other facilities used for preparing food or beverages primarily for consumption at the source.
- p. Equipment using water, water and soap or detergent, or a suspension of abrasives in water for purposes of cleaning or finishing provided no organic solvent has been added to the water, the boiling point of the additive is not less than 100°C (212°F), and the water is not heated above 65.5°C (150°F).

*q.* Administrative activities including, but not limited to, paper shredding, copying, photographic activities, and blueprinting machines. This does not include incinerators.

*r.* Laundry dryers, extractors, and tumblers processing clothing, bedding, and other fabric items used at the source that have been cleaned with water solutions of bleach or detergents provided that any organic solvent present in such items before processing that is retained from cleanup operations shall be addressed as part of the volatile organic compound emissions from use of cleaning materials.

*s.* Housekeeping activities for cleaning purposes, including collecting spilled and accumulated materials at the source, but not including use of cleaning materials that contain organic solvent.

*t.* Refrigeration systems, including storage tanks used in refrigeration systems, but excluding any combustion equipment associated with such systems.

*u.* Activities associated with the construction, on-site repair, maintenance or dismantlement of buildings, utility lines, pipelines, wells, excavations, earthworks and other structures that do not constitute emission units.

*v.* Storage tanks of organic liquids with a capacity of less than 500 gallons, provided the tank is not used for storage of any material listed as a hazardous air pollutant pursuant to Section 112(b) of the Clean Air Act.

*w.* Piping and storage systems for natural gas, propane, and liquified petroleum gas, excluding pipeline compressor stations and associated storage facilities.

*x.* Water treatment or storage systems, as follows:

(1) Systems for potable water or boiler feedwater.

(2) Systems, including cooling towers, for process water provided that such water has not been in direct or indirect contact with process steams that contain volatile organic material or materials listed as hazardous air pollutants pursuant to Section 112(b) of the Clean Air Act.

*y.* Lawn care, landscape maintenance, and groundskeeping activities.

*z.* Containers, reservoirs, or tanks used exclusively in dipping operations to coat objects with oils, waxes, or greases, provided no organic solvent has been mixed with such materials.

*aa.* Cold cleaning degreasers that are not in-line cleaning machines, where the vapor pressure of the solvents used never exceeds 2 kPa (15 mmHg or 0.3 psi) measured at 38°C (100°F) or 0.7 kPa (5 mmHg or 0.1 psi) at 20°C (68°F). (Note: Cold cleaners subject to 40 CFR Part 63 Subpart T are not considered insignificant activities.)

*bb.* Manually operated equipment used for buffing, polishing, carving, cutting, drilling, machining, routing, sanding, sawing, scarfing, surface grinding or turning.

*cc.* Use of consumer products, including hazardous substances as that term is defined in the Federal Hazardous Substances Act (15 U.S.C. 1261 et seq.), when the product is used at a source in the same manner as normal consumer use.

*dd.* Activities directly used in the diagnosis and treatment of disease, injury or other medical condition.

*ee.* Firefighting activities and training in preparation for fighting fires conducted at the source. (Note: Written notification pursuant to 567—paragraph 23.2(3) “g” is required at least ten working days before such action commences.)

*ff.* Activities associated with the construction, repair or maintenance of roads or other paved or open areas, including operation of street sweepers, vacuum trucks, spray trucks and other vehicles related to the control of fugitive emissions of such roads or other areas.

*gg.* Storage and handling of drums or other transportable containers when the containers are sealed during storage and handling.

*hh.* Individual points of emission or activities as follows:

(1) Individual flanges, valves, pump seals, pressure relief valves and other individual components that have the potential for leaks.

(2) Individual sampling points, analyzers, and process instrumentation, whose operation may result in emissions.

(3) Individual features of an emission unit such as each burner and sootblower in a boiler or each use of cleaning materials on a coating or printing line.

*ii.* Construction activities at a source solely associated with the modification or building of a facility, an emission unit or other equipment at the source. (Note: Notwithstanding the status of this activity as insignificant, a particular activity that entails modification or construction of an emission unit or construction of air pollution control equipment may require a construction permit pursuant to 22.1(455B) and may subsequently require a revised Title V operating permit. A revised Title V operating permit may also be necessary for operation of an emission unit after completion of a particular activity if the existing Title V operating permit does not accommodate the new state of the emission unit.)

*jj.* Activities at a source associated with the maintenance, repair, or dismantlement of an emission unit or other equipment installed at the source, including preparation for maintenance, repair or dismantlement, and preparation for subsequent startup, including preparation of a shutdown vessel for entry, replacement of insulation, welding and cutting, and steam purging of a vessel prior to startup.

**22.103(2)** *Insignificant activities which must be included in Title V operating permit applications.*

*a.* The following are insignificant activities based on potential emissions:

An emission unit which has the potential to emit less than:

5 tons per year of any regulated air pollutant, except:

2.5 tons per year of PM<sub>10</sub>,

0.52 tons per year of PM<sub>2.5</sub> (does not apply to emission units for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013),

2 lbs per year of lead or lead compounds (40 lbs per year for emission units for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013),

2500 lbs per year of any combination of hazardous air pollutants except high-risk pollutants,

1000 lbs per year of any individual hazardous air pollutant except high-risk pollutants,

250 lbs per year of any combination of high-risk pollutants, or

100 lbs per year of any individual high-risk pollutant.

The definition of “high-risk pollutant” is found in rule 567—22.100(455B).

*b.* The following are insignificant activities:

(1) Fuel-burning equipment for indirect heating and reheating furnaces using natural or liquefied petroleum gas with a capacity of less than 10 million Btu per hour input per combustion unit.

(2) Fuel-burning equipment for indirect heating for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013, with a capacity of less than 1 million Btu per hour input per combustion unit when burning coal, untreated wood, or fuel oil.

Fuel-burning equipment for indirect heating for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, with a capacity of less than 1 million Btu per hour input per combustion unit when burning untreated wood, untreated seeds or pellets, other untreated vegetative materials, or fuel oil provided that the equipment and the fuel meet the condition specified in this subparagraph (22.103(2)“b”(2)). Used oils meeting the specification from 40 CFR 279.11 as amended through May 3, 1993, are acceptable fuels. When combusting used oils, the equipment must have a maximum rated capacity of 50,000 Btu or less per hour of heat input or a maximum throughput of 3600 gallons or less of used oils per year. When combusting untreated wood, untreated seeds or pellets, or other untreated vegetative materials, the equipment must have a maximum rated capacity of 265,600 Btu or less per hour or a maximum throughput of 378,000 pounds or less per year of each fuel or any combination of fuels.

(3) Incinerators with a rated refuse burning capacity of less than 25 pounds per hour for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013. Incinerators for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall not qualify as an insignificant activity. After October 23, 2013, only paint clean-off ovens with a maximum rated capacity of less than 25 pounds per hour that do not combust lead-containing materials shall qualify as an insignificant activity.

(4) Gasoline, diesel fuel, or oil storage tanks with a capacity of 1,000 gallons or less and an annual throughput of less than 40,000 gallons.

(5) A storage tank which contains no volatile organic compounds above a vapor pressure of 0.75 pounds per square inch at the normal operating temperature of the tank when other emissions from the tank do not exceed the levels in paragraph 22.103(2) "a."

(6) Internal combustion engines that are used for emergency response purposes with a brake horsepower rating of less than 400 measured at the shaft. The manufacturer's nameplate rating at full load shall be defined as the brake horsepower output at the shaft.

[ARC 1013C, IAB 9/18/13, effective 10/23/13; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.104(455B) Requirement to have a Title V permit.** No source may operate after the time that it is required to submit a timely and complete application, except in compliance with a properly issued Title V operating permit. However, if a source submits a timely and complete application for permit issuance (including renewal), the source's failure to have a permit is not a violation of this chapter until the director takes final action on the permit application, except as noted in this rule. In that case, all terms and conditions of the permit shall remain in effect until the renewal permit has been issued or denied.

**22.104(1)** This protection shall cease to apply if, subsequent to the completeness determination, the applicant fails to submit, by the deadline specified in writing by the director, any additional information identified as being needed to process the application.

**22.104(2)** Sources making permit revisions pursuant to rule 567—22.110(455B) shall not be in violation of this rule.

**567—22.105(455B) Title V permit applications.**

**22.105(1) Duty to apply.** For each source required to obtain a Title V permit, the owner or operator or designated representative, where applicable, shall present or mail a complete and timely permit application in accordance with this rule to the following locations: Iowa Department of Natural Resources, Air Quality Bureau, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324 (two copies); and U.S. EPA Region VII, 901 North 5th Street, Kansas City, Kansas 66101 (one copy); and, if applicable, the local permitting authority, which is either Linn County Public Health Department, Air Quality Division, 501 13th Street NW, Cedar Rapids, Iowa 52405 (one copy); or Polk County Public Works, Air Quality Division, 5885 NE 14th Street, Des Moines, Iowa 50313 (one copy). Alternatively, an owner or operator may submit a complete and timely application through the electronic submittal format specified by the department. An owner or operator of a source required to obtain a Title V permit pursuant to subrule 22.101(1) shall submit all required fees as required in 567—Chapter 30.

*a. Timely application.* Each owner or operator applying for a Title V permit shall submit an application as follows:

(1) Initial application for an existing source. The owner or operator of a stationary source that was existing on or before April 20, 1994, shall make the first time submittals of a Title V permit application to the department by November 15, 1994. However, the owner or operator may choose to defer submittal of Part 2 of the permit application until December 31, 1995. The department will mail notice of the deadline for Part 2 of the permit application to all applicants who have filed Part 1 of the application by October 17, 1995.

(2) Initial application for a new source. The owner or operator of a stationary source that commenced construction or reconstruction after April 20, 1994, or that otherwise became subject to the requirement to obtain a Title V permit after April 20, 1994, shall submit an application to the department within 12 months of becoming subject to the Title V permit requirements.

(3) Application related to 112(g), PSD or nonattainment. The owner or operator of a stationary source that is subject to Section 112(g) of the Act, that is subject to rule 567—22.4(455B) or 567—33.3(455B) (prevention of significant deterioration (PSD)), or that is subject to rule 567—22.5(455B) or 567—31.3(455B) (nonattainment area permitting) shall submit an application to the department within 12 months of commencing operation. In cases in which an existing Title V

permit would prohibit such construction or change in operation, the owner or operator must obtain a Title V permit revision before commencing operation.

(4) Renewal application. The owner or operator of a stationary source with a Title V permit shall submit an application to the department for a permit renewal at least 6 months prior to, but not more than 18 months prior to, the date of permit expiration.

(5) Changes allowed without a permit revision (off-permit revision). The owner or operator of a stationary source with a Title V permit who is proposing a change that is allowed without a Title V permit revision (an off-permit revision) as specified in rule 567—22.110(455B) shall submit to the department a written notification as specified in rule 567—22.110(455B) at least 30 days prior to the proposed change.

(6) Application for an administrative permit amendment. Prior to implementing a change that satisfies the requirements for an administrative permit amendment as set forth in rule 567—22.111(455B), the owner or operator shall submit to the department an application for an administrative amendment as specified in rule 567—22.111(455B).

(7) Application for a minor permit modification. Prior to implementing a change that satisfies the requirements for a minor permit modification as set forth in rule 567—22.112(455B), the owner or operator shall submit to the department an application for a minor permit modification as specified in rule 567—22.112(455B).

(8) Application for a significant permit modification. The owner or operator of a source that satisfies the requirements for a significant permit modification as set forth in rule 567—22.113(455B) shall submit to the department an application for a significant permit modification as specified in rule 567—22.113(455B) within three months after the commencing operation of the changed source. However, if the existing Title V permit would prohibit such construction or change in operation, the owner or operator shall not commence operation of the changed source until the department issues a revised Title V permit that allows the change.

(9) Application for an acid rain permit. The owner or operator of a source subject to the acid rain program, as set forth in rules 567—22.120(455B) through 567—22.148(455B), shall submit an application for an initial Phase II acid rain permit by January 1, 1996 (for sulfur dioxide), or by January 1, 1998 (for nitrogen oxides).

*b. Complete application.* To be deemed complete, an application must provide all information required pursuant to subrule 22.105(2), except that applications for permit revision need supply such information only if it is related to the proposed change.

**22.105(2) Standard application form and required information.** To apply for a Title V permit, applicants shall complete the standard permit application form available only from the department and supply all information required by the filing instructions found on that form. The information submitted must be sufficient to evaluate the source and its application and to determine all applicable requirements and to evaluate the fee amount required by rule 567—30.4(455B). If a source is not a major source and is applying for a Title V operating permit solely because of a requirement imposed by paragraphs 22.101(1)“c” and “d,” then the information provided in the operating permit application may cover only the emissions units that trigger Title V applicability. The applicant shall submit the information called for by the application form for each emissions unit to be permitted, except for activities which are insignificant according to the provisions of rule 567—22.103(455B). The applicant shall provide a list of all insignificant activities and specify the basis for the determination of insignificance for each activity. Nationally standardized forms shall be used for the acid rain portions of permit applications and compliance plans, as required by regulations promulgated under Title IV of the Act. The standard application form and any attachments shall require that the following information be provided:

*a.* Identifying information, including company name and address (or plant or source name if different from the company name), owner’s name and agent, and telephone number and names of plant site manager/contact.

*b.* A description of the source’s processes and products (by two-digit Standard Industrial Classification Code) including any associated with each alternate scenario identified by the applicant.

*c.* The following emissions-related information shall be submitted to the department on the emissions inventory portion of the application:

(1) All emissions of pollutants for which the source is major, and all emissions of regulated air pollutants. The permit application shall describe all emissions of regulated air pollutants emitted from any emissions unit except where such units are exempted. The source shall submit additional information related to the emissions of air pollutants sufficient to verify which requirements are applicable to the source, and other information necessary to collect any permit fees owed under the approved fee schedule.

(2) Identification and description of all points of emissions in sufficient detail to establish the basis for fees and the applicability of any and all requirements.

(3) Emissions rates in tons per year and in such terms as are necessary to establish compliance consistent with the applicable standard reference test method, if any.

(4) The following information to the extent it is needed to determine or regulate emissions: fuels, fuel use, raw materials, production rates, and operating schedules.

(5) Identification and description of air pollution control equipment.

(6) Identification and description of compliance monitoring devices or activities.

(7) Limitations on source operations affecting emissions or any work practice standards, where applicable, for all regulated pollutants.

(8) Other information required by any applicable requirement (including information related to stack height limitations developed pursuant to Section 123 of the Act).

(9) Calculations on which the information in subparagraphs (1) to (8) above is based.

(10) Fugitive emissions from a source shall be included in the permit application in the same manner as stack emissions, regardless of whether the source category in question is included in the list of sources contained in the definition of major source.

*d.* The following air pollution control requirements:

(1) Citation and description of all applicable requirements, and

(2) Description of or reference to any applicable test method for determining compliance with each applicable requirement.

*e.* Other specific information that may be necessary to implement and enforce other applicable requirements of the Act or of these rules or to determine the applicability of such requirements.

*f.* An explanation of any proposed exemptions from otherwise applicable requirements.

*g.* Additional information as determined to be necessary by the director to define alternative operating scenarios identified by the source pursuant to subrule 22.108(12) or to define permit terms and conditions relating to operational flexibility and emissions trading pursuant to subrule 22.108(11) and rule 567—22.112(455B).

*h.* A compliance plan that contains the following:

(1) A description of the compliance status of the source with respect to all applicable requirements.

(2) The following statements regarding compliance status: For applicable requirements with which the stationary source is in compliance, a statement that the stationary source will continue to comply with such requirements. For applicable requirements that will become effective during the permit term, a statement that the stationary source will meet such requirements on a timely basis. For requirements for which the stationary source is not in compliance at the time of permit issuance, a narrative description of how the stationary source will achieve compliance with such requirements.

(3) A compliance schedule that contains the following:

1. For applicable requirements with which the stationary source is in compliance, a statement that the stationary source will continue to comply with such requirements. For applicable requirements that will become effective during the permit term, a statement that the stationary source will meet such requirements on a timely basis. A statement that the stationary source will meet in a timely manner applicable requirements that become effective during the permit term shall satisfy this provision, unless a more detailed schedule is expressly required by the applicable requirement.

2. A compliance schedule for sources that are not in compliance with all applicable requirements at the time of permit issuance. Such a schedule shall include a schedule of remedial measures, including an enforceable sequence of actions with milestones, leading to compliance with any applicable requirements for which the stationary source will be in noncompliance at the time of permit issuance.

3. This compliance schedule shall resemble and be at least as stringent as any compliance schedule contained in any judicial consent decree or administrative order to which the source is subject. Any compliance schedule shall be supplemental to, and shall not sanction noncompliance with, the applicable requirements on which it is based.

(4) A schedule for submission of certified progress reports no less frequently than every six months for sources required to have a compliance schedule in the permit.

*i.* Requirements for compliance certification, including the following:

(1) A certification of compliance for the prior year with all applicable requirements certified by a responsible official consistent with subrule 22.107(4) and Section 114(a)(3) of the Act.

(2) A statement of methods used for determining compliance, including a description of monitoring, record keeping, and reporting requirements and test methods.

(3) A schedule for submission of compliance certifications for each compliance period (one year unless required for a shorter time period by an applicable requirement) during the permit term, which shall be submitted annually, or more frequently if required by an underlying applicable requirement or by the director.

(4) A statement indicating the source's compliance status with any applicable enhanced monitoring and compliance certification requirements of the Act.

(5) Notwithstanding any other provisions of these rules, for the purposes of submission of compliance certifications, an owner or operator is not prohibited from using monitoring as required by subrules 22.108(3), 22.108(4) or 22.108(5) and incorporated into a Title V operating permit in addition to any specified compliance methods.

*j.* The compliance plan content requirements specified in these rules shall apply and be included in the acid rain portion of a compliance plan for a Title IV affected source, except as specifically superseded by regulations promulgated under Title IV of the Act, with regard to the schedule and method(s) the source shall use to achieve compliance with the acid rain emissions limitations.

**22.105(3) Hazardous air pollutant early reduction application.** Anyone requesting a compliance extension from a standard issued under Section 112(d) of the Act must submit with its Title V permit application information that complies with the requirements established in 567—paragraph 23.1(4) “d.”

**22.105(4) Acid rain application content.** The acid rain application content shall be as prescribed in the acid rain rules found at rules 567—22.128(455B) and 567—22.129(455B).

**22.105(5) More than one Title V operating permit for a stationary source.** Following application made pursuant to subrule 22.105(1), the department may, at its discretion, issue more than one Title V operating permit for a stationary source, provided that the owner or operator does not have, and does not propose to have, a sourcewide emission limit or a sourcewide alternative operating scenario.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.106(455B) Annual Title V emissions inventory.**

**22.106(1) Emissions fee.** Fees shall be paid as set forth in 567—Chapter 30.

**22.106(2) Emissions inventory and documentation due dates.** For emissions located in Polk County or Linn County, three copies of the following forms shall be submitted annually by March 31 documenting actual emissions for the previous calendar year. For emissions in all other counties, two copies of the following forms shall be submitted annually by March 31, documenting actual emissions for the previous calendar year:

- a.* Form 1.0, “Facility Identification”;
- b.* Form 4.0, “Emission Unit—Actual Operations and Emissions” for each emission unit;
- c.* Form 5.0, “Title V Annual Emissions Summary/Fee”; and
- d.* Part 3, “Application Certification.”

Alternatively, an owner or operator may submit the required emissions inventory information through the electronic submittal format specified by the department.

If there are any changes to the emission calculation form, the department shall make revised forms available to the public by January 1. If revised forms are not available by January 1, forms from the

previous year may be used and the year of emissions documented changed. The department shall calculate the total statewide Title V emissions for the prior calendar year and make this information available to the public no later than April 30 of each year.

**22.106(3) Correction of errors.** If an owner or operator, or the department, finds an error in a Title V emissions inventory, the owner or operator shall submit to the department revised forms making the necessary corrections to the Title V emissions inventory. Corrected forms shall be submitted as soon as possible after the errors are discovered or upon notification by the department.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.107(455B) Title V permit processing procedures.**

**22.107(1) Action on application.**

*a. Conditions for action on application.* A permit, permit modification, or renewal may be issued only if all of the following conditions have been met:

(1) The permitting authority has received a complete application for a permit, permit modification, or permit renewal, except that a complete application need not be received before issuance of a general permit under rule 567—22.109(455B);

(2) Except for modifications qualifying for minor permit modification procedures under rule 22.112(455B), the permitting authority has complied with the requirements for public participation under subrule 22.107(6);

(3) The permitting authority has complied with the requirements for notifying and responding to affected states under subrule 22.107(7);

(4) The conditions of the permit provide for compliance with all applicable requirements and the requirements of this chapter;

(5) The administrator has received a copy of the proposed permit and any notices required under subrule 22.107(7), and has not objected to issuance of the permit under subrule 22.107(7) within the time period specified therein;

(6) If the administrator has properly objected to the permit pursuant to the provisions of 40 CFR 70.8(d) as amended to July 21, 1992, or subrule 22.107(7), then the permitting authority may issue a permit only after the administrator's objection has been resolved; and

(7) No permit for a solid waste incineration unit combusting municipal waste subject to the provisions of Section 129(e) of the Act may be issued by an agency, instrumentality or person that is also responsible, in whole or part, for the design and construction or operation of the unit.

*b. Time for action on application.* The permitting authority shall take final action on each complete permit application (including a request for permit modification or renewal) within 18 months of receiving a complete application, except in the following instances:

(1) When otherwise provided under Title V or Title IV of the Act for the permitting of affected sources under the acid rain program.

(2) In the case of initial permit applications, the permitting authority may take up to three years from the effective date of the program to take final action on an application.

(3) Any complete permit applications containing an early reduction demonstration under Section 112(i)(5) of the Act shall be acted upon within nine months of receipt of the complete application.

*c. Prioritization of applications.* The director shall give priority to action on Title V applications involving construction or modification for which a construction permit pursuant to subrule 22.1(1) or Title I of the Act, Parts C and D, is also required. The director also shall give priority to action on Title V applications involving early reduction of hazardous air pollutants pursuant to 567—paragraph 23.1(4) "d."

*d. Completeness of applications.* The department shall promptly provide notice to the applicant of whether the application is complete. Unless the permitting authority requests additional information or otherwise notifies the applicant of incompleteness within 60 days of receipt of an application, the application shall be deemed complete. If, while processing an application that has been determined to be complete, the permitting authority determines that additional information is necessary to evaluate or take final action on that application, the permitting authority may request in writing such information

and set a reasonable deadline for a response. The source's ability to operate without a permit, as set forth in rule 567—22.104(455B), shall be in effect from the date the application is determined to be complete until the final permit is issued, provided that the applicant submits any requested additional information by the deadline specified by the permitting authority. For modifications processed through minor permit modification procedures, a completeness determination shall not be required.

*e. Decision to deny a permit application.* The director shall decide to issue or deny the permit. The director shall notify the applicant as soon as practicable that the application has been denied. Upon denial of the permit the provisions of paragraph 22.107(1) "d" shall no longer be applicable. The new application shall be regarded as an entirely separate application containing all the required information and shall not depend on references to any documents contained in the previous denied application.

*f. Fact sheet.* A draft permit and fact sheet shall be prepared by the permitting authority. The fact sheet shall include the rationale for issuance or denial of the permit; a brief description of the type of facility; a summary of the type and quantity of air pollutants being emitted; a brief summary of the legal and factual basis for the draft permit conditions, including references to applicable statutes and rules; a description of the procedures for reaching final decision on the draft permit including the comment period, the address where comments will be received, and procedures for requesting a hearing and the nature of the hearing; and the name and telephone number for a person to contact for additional information. The permitting authority shall provide the fact sheet to EPA and to any other person who requests it.

*g. Relation to construction permits.* The submittal of a complete application shall not affect the requirement that any source have a construction permit under Title I of the Act and subrule 22.1(1).

**22.107(2) Confidential information.** If a source has submitted information with an application under a claim of confidentiality to the department, the source shall also submit a copy of such information directly to the administrator. Requests for confidentiality must comply with 561—Chapter 2.

**22.107(3) Duty to supplement or correct application.** Any applicant who fails to submit any relevant facts or who has submitted incorrect information in a permit application shall, upon becoming aware of such failure or incorrect submittal, promptly submit such supplementary facts or corrected information. In addition, an applicant shall provide additional information as necessary to address any requirements that become applicable to the source after the date the source filed a complete application but prior to release of a draft permit. Applicants who have filed a complete application shall have 60 days following notification by the department to file any amendments. Any MACT determinations in permit applications will be evaluated based on the standards, limitations or levels of technology existing on the date the initial application is deemed complete.

**22.107(4) Certification of truth, accuracy, and completeness.** Any application form, report, or compliance certification submitted pursuant to these rules shall contain certification by a responsible official of truth, accuracy, and completeness. This certification and any other certification required under these rules shall state that, based on information and belief formed after reasonable inquiry, the statements and information in the document are true, accurate, and complete.

**22.107(5) Early reduction application evaluation.** Hazardous air pollutant early reduction application evaluation review shall follow the procedures established in 567—paragraph 23.1(4) "d."

**22.107(6) Public notice and public participation.**

*a.* The permitting authority shall provide public notice and an opportunity for public comments, including an opportunity for a hearing, before taking any of the following actions: issuance, denial or renewal of a permit; or significant modification or revocation or reissuance of a permit.

*b.* Notice shall be given by publication in a newspaper of general circulation in the area where the source is located or in a state publication designed to give general public notice. Notice also shall be given to persons on a mailing list developed by the permitting authority, including those who request in writing to be on the list. The department may use other means if necessary to ensure adequate notice to the affected public.

*c.* The public notice shall include the following:

- (1) Identification of the Title V source.
- (2) Name and address of the permittee.

- (3) Name and address of the permitting authority processing the permit.
- (4) The activity or activities involved in the permit action.
- (5) The emissions change involved in any permit modification.
- (6) The air pollutants or contaminants to be emitted.
- (7) The time and place of any possible public hearing.
- (8) A statement that any person may submit written and signed comments, or may request a public hearing, or both, on the proposed permit. A statement of procedures to request a public hearing shall be included.

(9) The name, address, and telephone number of a person from whom additional information may be obtained. Information entitled to confidential treatment pursuant to Section 114(c) of the Act or state law shall not be released pursuant to this provision. However, the contents of a Title V permit shall not be entitled to protection under Section 114(c) of the Act.

(10) Locations where copies of the permit application and the proposed permit may be reviewed, including the closest department office, and the times at which they shall be available for public inspection.

*d.* At least 30 days shall be provided for public comment. Notice of any public hearing shall be given at least 30 days in advance of the hearing.

*e.* Any person may request a public hearing. A request for a public hearing shall be in writing and shall state the person's interest in the subject matter and the nature of the issues proposed to be raised at the hearing. The director shall hold a public hearing upon finding, on the basis of requests, a significant degree of relevant public interest in a draft permit. A public hearing also may be held at the director's discretion.

*f.* The director shall keep a record of the commenters and of the issues raised during the public participation process and shall prepare written responses to all comments received. At the time a final decision is made, the record and copies of the director's responses shall be made available to the public.

*g.* The permitting authority shall provide notice and opportunity for participation by affected states as provided by subrule 22.107(7).

**22.107(7) Permit review by EPA and affected states.**

*a. Transmission of information to the administrator.* Except as provided in subrule 22.107(2) or waived by the administrator, the director shall provide to the administrator a copy of each permit application or modification application, including any attachments and compliance plans; each proposed permit; and each final permit. For purposes of this subrule, the application information may be submitted in a computer-readable format compatible with the administrator's national database management system.

*b. Review by affected states.* The director shall provide notice of each draft permit to any affected state on or before the time that public notice is provided to the public pursuant to subrule 22.107(6), except to the extent that subrule 22.112(3) requires the timing of the notice to be different. If the director refuses to accept a recommendation of any affected state, submitted during the public or affected state review period, then the director shall notify the administrator and the affected state in writing. The notification shall include the director's reasons for not accepting the recommendation(s). The director shall not be required to accept recommendations that are not based on applicable requirements.

*c. EPA objection.* No permit for which an application must be transmitted to the administrator shall be issued if the administrator objects in writing to its issuance as not in compliance with the applicable requirements within 45 days after receiving a copy of the proposed permit and necessary supporting information under 22.107(7) "a." Within 90 days after the date of an EPA objection made pursuant to this rule, the director shall submit a response to the objection, if the objection has not been resolved.

**22.107(8) Public petitions to the administrator regarding Title V permits.**

*a.* If the administrator does not object to a proposed permit, any person may petition the administrator within 60 days after the expiration of the administrator's 45-day review period to make an objection pursuant to 40 CFR 70.8(d) as amended to July 21, 1992.

*b.* Any person who petitions the administrator pursuant to the provisions of 40 CFR 70.8(d) as amended to July 21, 1992, shall notify the department by certified mail of such petition immediately,

and in no case more than 10 days following the date the petition is submitted to EPA. Such notice shall include a copy of the petition submitted to EPA and a separate written statement detailing the grounds for the objection(s) and whether the objection(s) was raised during the public comment period. A petition for review shall not stay the effectiveness of a permit or its requirements if the permit was issued after the end of the 45-day EPA review period and prior to the administrator's objection.

c. If the administrator objects to the permit as a result of a petition filed pursuant to 40 CFR 70.8(d) as amended to July 21, 1992, then the director shall not issue a permit until the administrator's objection has been resolved. However, if the director has issued a permit prior to receipt of the administrator's objection, and the administrator modifies, terminates, or revokes such permit, consistent with the procedures in 40 CFR 70.7 as amended to July 21, 1992, then the director may thereafter issue only a revised permit that satisfies the administrator's objection. In any case, the source shall not be in violation of the requirement to have submitted a timely and complete application.

**22.107(9)** *A Title V permit application may be denied if:*

- a. The director finds that a source is not in compliance with any applicable requirement; or
- b. An applicant knowingly submits false information in a permit application.

**22.107(10)** *Retention of permit records.* The director shall keep all records associated with each permit for a minimum of five years.

**567—22.108(455B) Permit content.** Each Title V permit shall include the following elements:

**22.108(1)** Enforceable emission limitations and standards. Each permit issued pursuant to this chapter shall include emissions limitations and standards, including those operational requirements and limitations that ensure compliance with all applicable requirements at the time of permit issuance.

a. The permit shall specify and reference the origin of and authority for each term or condition and identify any difference in form as compared to the applicable requirement upon which the term or condition is based.

b. The permit shall state that, where an applicable requirement of the Act is more stringent than an applicable requirement of regulations promulgated under Title IV of the Act, both provisions shall be incorporated into the permit and shall be enforceable by the administrator.

c. If an applicable implementation plan allows a determination of an alternative emission limit at a Title V source, equivalent to that contained in the plan, to be made in the permit issuance, renewal, or significant modification process, and the state elects to use such process, then any permit containing such equivalency determination shall contain provisions to ensure that any resulting emissions limit has been demonstrated to be quantifiable, accountable, enforceable, and based on replicable procedures.

d. If an early reduction demonstration is approved as part of the Title V permit application, the permit shall include enforceable alternative emissions limitations for the source reflecting the reduction which qualified the source for the compliance extension.

e. Fugitive emissions from a source shall be included in the permit in the same manner as stack emissions, regardless of whether the source category in question is included in the list of sources contained in the definition of major source.

f. For all major sources, all applicable requirements for all relevant emissions units in the major source shall be included in the permit.

**22.108(2)** Permit duration. The permit shall specify a fixed term not to exceed five years except:

- a. Permits issued to Title IV affected sources shall have a fixed term of five years.
- b. Permits issued to solid waste incineration units combusting municipal waste subject to standards under Section 129(e) of the Act shall have a term not to exceed 12 years. Such permits shall be reviewed every five years.

**22.108(3)** Monitoring. Each permit shall contain the following requirements with respect to monitoring:

a. All emissions monitoring and analysis procedures or test methods required under the applicable requirements, including any procedures and methods promulgated pursuant to Section 114(a)(3) or 504(b) of the Act;

*b.* Where the applicable requirement does not require periodic testing or instrumental or noninstrumental monitoring (which may consist of record keeping designed to serve as monitoring), periodic monitoring sufficient to yield reliable data from the relevant time period that are representative of the source's compliance with the permit, as reported pursuant to subrule 22.108(5). Such monitoring shall be determined by application of the "Periodic Monitoring Guidance" (as amended through October 24, 2012) available from the department;

*c.* As necessary, requirements concerning the use, maintenance, and, where appropriate, installation of monitoring equipment or methods; and

*d.* As required, Compliance Assurance Monitoring (CAM) consistent with 40 CFR Part 64 (as amended through October 22, 1997).

**22.108(4)** Record keeping. With respect to record keeping, the permit shall incorporate all applicable record-keeping requirements and require, where applicable, the following:

*a.* Records of required monitoring information that include the following:

- (1) The date, place as defined in the permit, and time of sampling or measurements;
- (2) The date(s) the analyses were performed;
- (3) The company or entity that performed the analyses;
- (4) The analytical techniques or methods used;
- (5) The results of such analyses; and
- (6) The operating conditions as existing at the time of sampling or measurement; and

*b.* Retention of records of all required monitoring data and support information for a period of at least five years from the date of the monitoring sample, measurement, report, or application. Support information includes all calibration and maintenance records and all original strip-chart and other recordings for continuous monitoring instrumentation, and copies of all reports required by the permit.

**22.108(5)** Reporting. With respect to reporting, the permit shall incorporate all applicable reporting requirements and shall require the following:

*a.* Submittal of reports of any required monitoring at least every six months. All instances of deviations from permit requirements must be clearly identified in such reports. All required reports must be certified by a responsible official consistent with subrule 22.107(4).

*b.* Prompt reporting of deviations from permit requirements, including those attributable to upset conditions as defined in the permit, the probable cause of such deviations, and any corrective actions or preventive measures taken. The director shall define "prompt" in relation to the degree and type of deviation likely to occur and the applicable requirements.

**22.108(6)** Risk management plan. Pursuant to Section 112(r)(7)(E) of the Act, if the source is required to develop and register a risk management plan pursuant to Section 112(r) of the Act, the permit shall state the requirement for submission of the plan to the air quality bureau of the department. The permit shall also require filing the plan with appropriate authorities and an annual certification to the department that the plan is being properly implemented.

**22.108(7)** A permit condition prohibiting emissions exceeding any allowances that the affected source lawfully holds under Title IV of the Act or the regulations promulgated thereunder.

*a.* No permit revision shall be required for increases in emissions that are authorized by allowances acquired pursuant to the acid rain program, provided that such increases do not require a permit revision under any other applicable requirement.

*b.* No limit shall be placed on the number of allowances held by the Title IV affected source. The Title IV affected source may not, however, use allowances as a defense to noncompliance with any other applicable requirement.

*c.* Any such allowances shall be accounted for according to the procedures established in regulations promulgated under Title IV of the Act.

*d.* Any permit issued pursuant to the requirements of these rules and Title V of the Act to a unit subject to the provisions of Title IV of the Act shall include conditions prohibiting all of the following:

- (1) Annual emissions of sulfur dioxide in excess of the number of allowances to emit sulfur dioxide held by the owners or operators of the unit or the designated representative of the owners or operators.
- (2) Exceedences of applicable emission rates.

- (3) The use of any allowance prior to the year for which it was allocated.
- (4) Contravention of any other provision of the permit.

**22.108(8)** Severability clause. The permit shall contain a severability clause to ensure the continued validity of the various permit requirements in the event of a challenge to any portions of the permit.

**22.108(9)** Other provisions. The Title V permit shall contain provisions stating the following:

*a.* The permittee must comply with all conditions of the Title V permit. Any permit noncompliance constitutes a violation of the Act and is grounds for enforcement action; for a permit termination, revocation and reissuance, or modification; or for denial of a permit renewal application.

*b.* Need to halt or reduce activity not a defense. It shall not be a defense for a permittee in an enforcement action that it would have been necessary to halt or reduce the permitted activity in order to maintain compliance with the conditions of the permit.

*c.* The permit may be modified, revoked, reopened, and reissued, or terminated for cause. The filing of a request by the permittee for a permit modification, revocation and reissuance, or termination, or of a notification of planned changes or anticipated noncompliance does not stay any permit condition.

*d.* The permit does not convey any property rights of any sort, or any exclusive privilege.

*e.* The permittee shall furnish to the director, within a reasonable time, any information that the director may request in writing to determine whether cause exists for modifying, revoking and reissuing, or terminating the permit or to determine compliance with the permit. Upon request, the permittee also shall furnish to the director copies of records required to be kept by the permit or, for information claimed to be confidential, the permittee shall furnish such records directly to the administrator of EPA along with a claim of confidentiality.

**22.108(10)** Fees. The permit shall include a provision to ensure that the Title V permittee pays fees to the director pursuant to rule 567—30.4(455B).

**22.108(11)** Emissions trading. A provision of the permit shall state that no permit revision shall be required, under any approved economic incentives, marketable permits, emissions trading and other similar programs or processes for changes that are provided for in the permit.

**22.108(12)** Terms and conditions for reasonably anticipated operating scenarios identified by the source in its application and as approved by the director. Such terms and conditions:

*a.* Shall require the source, contemporaneously with making a change from one operating scenario to another, to record in a log at the permitted facility a record of the scenario under which it is operating; and

*b.* Must ensure that the terms and conditions of each such alternative scenario meet all applicable requirements and the requirements of the department's rules.

**22.108(13)** Terms and conditions, if the permit applicant requests them, for the trading of emissions increases and decreases in the permitted facility, to the extent that the applicable requirements provide for trading such increases and decreases without a case-by-case approval of each emissions trade. Such terms and conditions:

*a.* Shall include all terms required under subrules 22.108(1) to 22.108(13) and subrule 22.108(15) to determine compliance;

*b.* Must meet all applicable requirements of the Act and regulations promulgated thereunder and all requirements of this chapter; and

*c.* May extend the permit shield described in subrule 22.108(18) to all terms and conditions that allow such increases and decreases in emissions.

**22.108(14)** Federally enforceable requirements.

*a.* All terms and conditions in a Title V permit, including any provisions designed to limit a source's potential to emit, are enforceable by the administrator and citizens under the Act.

*b.* Notwithstanding paragraph "a" of this subrule, the director shall specifically designate as not being federally enforceable under the Act any terms and conditions included in the permit that are not required under the Act or under any of its applicable requirements. Terms and conditions so designated are not subject to the requirements of 40 CFR 70.7 or 70.8 (as amended through July 21, 1992).

**22.108(15)** Compliance requirements. All Title V permits shall contain the following elements with respect to compliance:

*a.* Consistent with the provisions of subrules 22.108(3) to 22.108(5), compliance certification, testing, monitoring, reporting, and record-keeping requirements sufficient to ensure compliance with the terms and conditions of the permit. Any documents, including reports, required by a permit shall contain a certification by a responsible official that meets the requirements of subrule 22.107(4).

*b.* Inspection and entry provisions which require that, upon presentation of proper credentials, the permittee shall allow the director or the director's authorized representative to:

(1) Enter upon the permittee's premises where a Title V source is located or emissions-related activity is conducted, or where records must be kept under the conditions of the permit;

(2) Have access to and copy, at reasonable times, any records that must be kept under the conditions of the permit;

(3) Inspect, at reasonable times, any facilities, equipment (including monitoring and air pollution control equipment), practices, or operations regulated or required under the permit; and

(4) Sample or monitor, at reasonable times, substances or parameters for the purpose of ensuring compliance with the permit or other applicable requirements.

*c.* A schedule of compliance consistent with subparagraphs 22.105(2) "h" and "j" and subrule 22.105(3).

*d.* Progress reports, consistent with an applicable schedule of compliance and with the provisions of paragraphs 22.105(2) "h" and "j," to be submitted at least every six months, or more frequently if specified in the applicable requirement or by the department in the permit. Such progress reports shall contain the following:

(1) Dates for achieving the activities, milestones or compliance required in the schedule of compliance, and dates when such activities, milestones or compliance were achieved; and

(2) An explanation of why any dates in the schedule of compliance were not or will not be met, and any preventive or corrective measures adopted.

*e.* Requirements for compliance certification with terms and conditions contained in the permit, including emission limitations, standards, or work practices. Permits shall include each of the following:

(1) The frequency of submissions of compliance certifications, which shall not be less than annually.

(2) The means to monitor the compliance of the source with its emissions limitations, standards, and work practices, in accordance with the provisions of all applicable department rules.

(3) A requirement that the compliance certification include: the identification of each term or condition of the permit that is the basis of the certification; the compliance status; whether compliance was continuous or intermittent; the method(s) used for determining the compliance status of the source, currently and over the reporting period consistent with all applicable department rules; and other facts as the director may require to determine the compliance status of the source.

(4) A requirement that all compliance certifications be submitted to the administrator and the director.

*f.* Such additional provisions as the director may require.

*g.* Such additional provisions as may be specified pursuant to Sections 114(a)(3) and 504(b) of the Act.

*h.* If there is a federal implementation plan applicable to the source, a provision that compliance with the federal implementation plan is required.

#### **22.108(16) Emergency provisions.**

*a.* For the purposes of a Title V permit, an "emergency" means any situation arising from sudden and reasonably unforeseeable events beyond the control of the source, including acts of God, which situation requires immediate corrective action to restore normal operation, and that causes the source to exceed a technology-based emission limitation under the permit, due to unavoidable increases in emissions attributable to the emergency. An emergency shall not include noncompliance to the extent caused by improperly designed equipment, lack of preventive maintenance, careless or improper operation, or operator error.

*b.* An emergency constitutes an affirmative defense to an action brought for noncompliance with such technology-based emission limitations if the conditions of paragraph 22.108(16) "c" are met.

*c.* Requirements for affirmative defense. The affirmative defense of emergency shall be demonstrated by the source through properly signed, contemporaneous operating logs, or other relevant evidence that:

- (1) An emergency occurred and that the permittee can identify the cause(s) of the emergency;
- (2) The permitted facility was at the time being properly operated;
- (3) During the period of the emergency the permittee took all reasonable steps to minimize levels of emissions that exceeded the emissions standards or other requirements of the permit; and
- (4) The permittee submitted notice of the emergency to the director by certified mail within two working days of the time when emission limitations were exceeded due to the emergency. This notice fulfills the requirement of paragraph 22.108(5) "b." This notice must contain a description of the emergency, any steps taken to mitigate emissions, and corrective actions taken.

*d.* In any enforcement proceeding, the permittee seeking to establish the occurrence of an emergency has the burden of proof.

*e.* This provision is in addition to any emergency or upset provision contained in any applicable requirement.

**22.108(17) Permit reopenings.**

*a.* A Title V permit issued to a major source shall require that revisions be made to incorporate applicable standards and regulations adopted by the administrator pursuant to the Act, provided that:

- (1) The reopening and revision on this ground is not required if the permit has a remaining term of less than three years;
- (2) The reopening and revision on this ground is not required if the effective date of the requirement is later than the date on which the permit is due to expire, unless the original permit or any of its terms and conditions have been extended pursuant to 40 CFR 70.4(b)(10)(i) or (ii) as amended to May 15, 2001; or
- (3) The additional applicable requirements are implemented in a general permit that is applicable to the source and the source receives approval for coverage under that general permit.

*b.* The revisions shall be made as expeditiously as practicable, but not later than 18 months after the promulgation of such standards and regulations. Any permit revision required pursuant to this subrule shall be treated as a permit renewal.

**22.108(18) Permit shield.**

*a.* The director may expressly include in a Title V permit a provision stating that compliance with the conditions of the permit shall be deemed compliance with any applicable requirements as of the date of permit issuance, provided that:

- (1) Such applicable requirements are included and are specifically identified in the permit; or
- (2) The director, in acting on the permit application or revision, determines in writing that other requirements specifically identified are not applicable to the source, and the permit includes the determination or a concise summary thereof.

*b.* A Title V permit that does not expressly state that a permit shield exists shall be presumed not to provide such a shield.

*c.* A permit shield shall not alter or affect the following:

- (1) The provisions of Section 303 of the Act (emergency orders), including the authority of the administrator under that section;
- (2) The liability of an owner or operator of a source for any violation of applicable requirements prior to or at the time of permit issuance;
- (3) The applicable requirements of the acid rain program, consistent with Section 408(a) of the Act;
- (4) The ability of the department or the administrator to obtain information from the facility pursuant to Section 114 of the Act.

**22.108(19) Emission trades.** For emission trades at facilities solely for the purpose of complying with a federally enforceable emissions cap that is established in the permit independent of otherwise applicable requirements, permit applications under this provision are required to include proposed

replicable procedures and proposed permit terms that ensure the emission trades are quantifiable and enforceable.

[ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 2352C, IAB 1/6/16, effective 12/16/15]

### **567—22.109(455B) General permits.**

**22.109(1) *Applicability.*** The director may issue a general permit for multiple sources that contain a number of operations and processes which emit pollutants with similar characteristics and that have substantially similar requirements regarding emissions, operations, monitoring and record keeping. General permits shall not be issued to Title IV affected sources except as provided in regulations promulgated by the administrator under Title IV of the Act.

**22.109(2) *Issuance of general permits.*** General permits may be issued by the director and codified in this chapter following notice and opportunity for public participation consistent with the procedures contained in subrule 22.107(6). Public participation shall be provided for a new general permit, for any revision of an existing general permit, and for renewal of an existing general permit. Permit review by the administrator and affected states shall be provided consistent with subrule 22.107(7). Each general permit shall identify criteria by which sources may qualify to operate under the general permit and shall comply with all requirements applicable to other Title V permits.

**22.109(3) *Applications.*** Any source that would qualify for a general permit must apply for either (a) coverage under the terms of the general permit or (b) an individual Title V permit. Applications for authority to operate under the terms of a general permit shall be made on the “General Permit Application Form” and shall specify the general permit concerned by citing the subrule containing that general permit. These applications may deviate from the Title V individual permit application but shall include all information necessary to determine qualification for, and to ensure compliance with, the general permit. If a source is later determined not to qualify for the terms and conditions of the general permit, then the source shall be subject to enforcement action for operation without a Title V operating permit.

**22.109(4) *General permit content.*** A general permit shall include all of the following:

- a. The terms and conditions required for all sources authorized to operate under the permit;
- b. Emission limitations and standards, including those operational requirements and limitations that ensure compliance with all applicable requirements at the time of the permit issuance;
- c. A compliance plan;
- d. Monitoring, record keeping, and reporting requirements to ensure compliance with the terms and conditions of the general permit. These requirements shall ensure the use of consistent terms, test methods, units, averaging periods, and other statistical conventions consistent with the applicable emissions limitations, standards, and other requirements contained in the general permit;
- e. The requirement to submit at least every six months the results of any required monitoring;
- f. References to the authority for the term or condition;
- g. A provision specifying permit duration as a fixed term not to exceed five years;
- h. A severability clause provision pursuant to subrule 22.108(8);
- i. A provision for payment of fees pursuant to subrule 22.108(10);
- j. A provision for emissions trading pursuant to subrules 22.108(11) and 22.108(13);
- k. Other provisions pursuant to subrule 22.108(9);
- l. Statement that the Title V permit is to be kept at the site of the source as well as at the corporate offices; and
- m. The process for individual sources to apply for coverage under the general permit.

**22.109(5) *Action on general permit application.***

a. Once the director has issued a general permit, any source which is a member of the class of sources covered by the general permit may apply to the director for authority to operate under the general permit.

b. Review of a general permit application. The director shall grant the conditions and terms of a general permit to all sources that apply and qualify under the identified criteria.

c. The director may grant a source's request for authorization to operate under a general permit without repeating the public participation procedures followed in subrule 22.109(2). However, such a grant shall not be a final permit action for purposes of judicial review.

**22.109(6) *General permit renewal.*** The director shall review and may renew general permits every five years. A source's authorization to operate under a general permit shall expire when the general permit expires regardless of when the authorization began during the five-year period.

**22.109(7) *Relationship to individual permits.*** Any source covered by a general permit may request to be excluded from coverage by applying for an individual Title V permit. Coverage under the general permit shall terminate on the date the individual Title V permit is issued.

**22.109(8) *Permit shield for general permit.*** Each general permit issued under this chapter shall specifically identify all federal, state, and local air pollution control requirements applicable to the source at the time the permit is issued. The permit shall state that compliance with the conditions of the permit shall be deemed compliance with any applicable requirements as of the date of permit issuance. Any permit under this chapter that does not expressly state that a permit shield exists shall be presumed not to provide such a shield. Notwithstanding the above provisions, the source shall be subject to enforcement action for operation without a permit if the source is later determined not to qualify for the conditions and terms of the general permit.

**22.109(9) *Revocations of authority to operate.***

a. The director may require any source or a class of sources authorized to operate under a general permit to individually apply for and obtain a Title V permit at any time if:

- (1) The source is not in compliance with the terms and conditions of the general permit;
- (2) The director has determined that the emissions from the source or class of sources is contributing significantly to ambient air quality standard violations and that these emissions are not adequately addressed by the terms and conditions of the general permit; or
- (3) The director has information which indicates that the cumulative effects on human health and the environment from the sources covered under the general permit are unacceptable.

b. The director shall provide written notice to all sources operating under that general permit of the proposed revocation of that general permit. Such notice shall include an explanation of the basis for the proposed action.

**567—22.110(455B) Changes allowed without a Title V permit revision (off-permit revisions).**

**22.110(1)** A source with a Title V permit may make Section 502(b)(10) changes to the permitted installation/facility without a Title V permit revision if:

a. The changes are not major modifications under any provision of any program required by Section 110 of the Act, modifications under Section 111 of the Act, modifications under Section 112 of the Act, or major modifications of this chapter;

b. The changes do not exceed the emissions allowable under the permit (whether expressed therein as a rate of emissions or in terms of total emissions);

c. The changes are not modifications under any provision of Title I of the Act and the changes do not exceed the emissions allowable under the permit (whether expressed therein as a rate of emissions or in terms of total emissions);

d. The changes are not subject to any requirement under Title IV of the Act (revisions affecting Title IV permitting are addressed in rules 567—22.140(455B) through 567—22.144(455B));

e. The changes comply with all applicable requirements; and

f. For each such change, the permitted source provides to the department and the administrator by certified mail, at least 30 days in advance of the proposed change, a written notification, including the following, which shall be attached to the permit by the source, the department, and the administrator:

- (1) A brief description of the change within the permitted facility,
- (2) The date on which the change will occur,
- (3) Any change in emission as a result of the change,
- (4) The pollutants emitted subject to the emissions trade,

(5) If the emissions trading provisions of the state implementation plan are invoked, then the Title V permit requirements with which the source shall comply; a description of how the emission increases and decreases will comply with the terms and conditions of the Title V permit;

(6) A description of the trading of emissions increases and decreases for the purpose of complying with a federally enforceable emissions cap as specified in and in compliance with the Title V permit; and

(7) Any permit term or condition no longer applicable as a result of the change.

**22.110(2)** Such changes do not include changes that would violate applicable requirements or contravene federally enforceable permit terms and conditions that are monitoring (including test methods), record keeping, reporting, or compliance certification requirements.

**22.110(3)** Notwithstanding any other part of this rule, the director may, upon review of a notice, require a stationary source to apply for a Title V permit if the change does not meet the requirements of subrule 22.110(1).

**22.110(4)** The permit shield provided in subrule 22.108(18) shall not apply to any change made pursuant to this rule. Compliance with the permit requirements that the source will meet using the emissions trade shall be determined according to requirements of the state implementation plan authorizing the emissions trade.

**567—22.111(455B) Administrative amendments to Title V permits.**

**22.111(1)** An administrative permit amendment is a permit revision that does any of the following:

- a. Corrects typographical errors;
- b. Identifies a change in the name, address, or telephone number of any person identified in the permit, or provides a similar minor administrative change at the source;
- c. Requires more frequent monitoring or reporting by the permittee; or
- d. Allows for a change in ownership or operational control of a source where the director determines that no other change in the permit is necessary, provided that a written agreement containing a specific date for transfer of permit responsibility, coverage, and liability between the current and new permittee has been submitted to the director.

**22.111(2)** Administrative permit amendments to portions of permits containing provisions pursuant to Title IV of the Act shall be governed by regulations promulgated by the administrator under Title IV of the Act.

**22.111(3)** The director shall take no more than 60 days from receipt of a request for an administrative permit amendment to take final action on such request, and may incorporate such changes without providing notice to the public or affected states provided that the director designates any such permit revisions as having been made pursuant to this rule.

**22.111(4)** The director shall submit to the administrator a copy of each Title V permit revised under this rule.

**22.111(5)** The source may implement the changes addressed in the request for an administrative amendment immediately upon submittal of the request.

**567—22.112(455B) Minor Title V permit modifications.**

**22.112(1)** Minor Title V permit modification procedures may be used only for those permit modifications that satisfy all of the following:

- a. Do not violate any applicable requirement;
- b. Do not involve significant changes to existing monitoring, reporting, or record-keeping requirements in the Title V permit;
- c. Do not require or change a case-by-case determination of an emission limitation or other standard, or an increment analysis;
- d. Do not seek to establish or change a permit term or condition for which there is no corresponding underlying applicable requirement and that the source has assumed in order to avoid an applicable requirement to which the source would otherwise be subject. Such terms and conditions include any federally enforceable emissions caps which the source would assume to avoid classification

as a modification under any provision of Title I of the Act; and an alternative emissions limit approved pursuant to regulations promulgated under Section 112(i)(5) of the Act;

- e.* Are not modifications under any provision of Title I of the Act; and
- f.* Are not required to be processed as a significant modification under rule 567—22.113(455B).

**22.112(2)** An application for minor permit revision shall be on the minor Title V modification application form and shall include at least the following:

- a.* A description of the change, the emissions resulting from the change, and any new applicable requirements that will apply if the change occurs;
- b.* The source's suggested draft permit;
- c.* Certification by a responsible official, pursuant to subrule 22.107(4), that the proposed modification meets the criteria for use of minor permit modification procedures and a request that such procedures be used; and
- d.* Completed forms to enable the department to notify the administrator and affected states as required by subrule 22.107(7).

**22.112(3)** The department shall notify the administrator and affected states within five working days of receipt of a complete permit modification application. Notification shall be in accordance with the provisions of subrule 22.107(7). The department shall promptly send to the administrator any notification required by subrule 22.107(7).

**22.112(4)** The director shall not issue a final Title V permit modification until after the administrator's 45-day review period or until the administrator has notified the director that the administrator will not object to issuance of the Title V permit modification, whichever is first. Within 90 days of the director's receipt of an application under the minor permit modification procedures, or 15 days after the end of the administrator's 45-day review period provided for in subrule 22.107(7), whichever is later, the director shall:

- a.* Issue the permit modification as proposed;
- b.* Deny the permit modification application;
- c.* Determine that the requested permit modification does not meet the minor permit modification criteria and should be reviewed under the significant modification procedures; or
- d.* Revise the draft permit modification and transmit to the administrator the proposed permit modification, as required by subrule 22.107(7).

**22.112(5)** Source's ability to make change. The source may make the change proposed in its minor permit modification application immediately after it files the application. After the source makes the change allowed by the preceding sentence, and until the director takes any of the actions specified in paragraphs 22.112(4) "a" to "c," the source must comply with both the applicable requirements governing the change and the proposed permit terms and conditions. During this time, the source need not comply with the existing permit terms and conditions it seeks to modify. However, if the source fails to comply with its proposed permit terms and conditions during this time period, the existing permit terms and conditions it seeks to modify may be enforced against it.

**22.112(6)** Permit shield. The permit shield under subrule 22.108(18) shall not extend to minor Title V permit revisions.

#### **567—22.113(455B) Significant Title V permit modifications.**

**22.113(1)** Significant Title V modification procedures shall be used for applications requesting Title V permit modifications that do not qualify as minor Title V modifications or as administrative amendments. These include, but are not limited to, all significant changes in monitoring permit terms, every relaxation of reporting or record-keeping permit terms, and any change in the method of measuring compliance with existing requirements.

**22.113(2)** Significant Title V permit modifications shall meet all requirements of this chapter, including those for applications, public participation, review by affected states, and review by the administrator, as those requirements that apply to Title V permit issuance and renewal.

**22.113(3)** Unless the director determines otherwise, review of significant Title V permit modification applications shall be completed within nine months of receipt of a complete application.

**22.113(4)** For a change that is subject to the requirements for a significant permit modification (see rule 567—22.113(455B)), the permittee shall submit to the department an application for a significant permit modification not later than three months after commencing operation of the changed source unless the existing Title V permit would prohibit such construction or change in operation, in which event the operation of the changed source may not commence until the department revises the permit.

**567—22.114(455B) Title V permit reopenings.**

**22.114(1)** Each issued Title V permit shall include provisions specifying the conditions under which the permit may be reopened and revised prior to the expiration of the permit. A permit shall be reopened and revised under any of the following circumstances:

*a.* The department receives notice that the administrator has granted a petition for disapproval of a permit pursuant to 40 CFR 70.8(d) as amended to July 21, 1992, provided that the reopening may be stayed pending judicial review of that determination;

*b.* The department or the administrator determines that the Title V permit contains a material mistake or that inaccurate statements were made in establishing the emissions standards or other terms or conditions of the Title V permit;

*c.* Additional applicable requirements under the Act become applicable to a Title V source, provided that the reopening on this ground is not required if the permit has a remaining term of less than three years, the effective date of the requirement is later than the date on which the permit is due to expire, or the additional applicable requirements are implemented in a general permit that is applicable to the source and the source receives approval for coverage under that general permit. Such a reopening shall be complete not later than 18 months after promulgation of the applicable requirement.

*d.* Additional requirements, including excess emissions requirements, become applicable to a Title IV affected source under the acid rain program. Upon approval by the administrator, excess emissions offset plans shall be deemed to be incorporated into the permit.

*e.* The department or the administrator determines that the permit must be revised or revoked to ensure compliance by the source with the applicable requirements.

**22.114(2)** Proceedings to reopen and reissue a Title V permit shall follow the procedures applicable to initial permit issuance and shall affect only those parts of the permit for which cause to reopen exists.

**22.114(3)** A notice of intent shall be provided to the Title V source at least 30 days in advance of the date the permit is to be reopened, except that the director may provide a shorter time period in the case of an emergency.

**22.114(4)** Within 90 days of receipt of a notice from the administrator that cause exists to reopen a permit, the director shall forward to the administrator and the source a proposed determination of termination, modification, revocation, or reissuance of the permit, as appropriate.

**567—22.115(455B) Suspension, termination, and revocation of Title V permits.**

**22.115(1)** Permits may be terminated, modified, revoked, or reissued for cause. The following examples shall be considered cause for the suspension, modification, revocation, or reissuance of a Title V permit:

*a.* The director has reasonable cause to believe that the permit was obtained by fraud or misrepresentation.

*b.* The person applying for the permit failed to disclose a material fact required by the permit application form or the rules applicable to the permit, of which the applicant had or should have had knowledge at the time the application was submitted.

*c.* The terms and conditions of the permit have been or are being violated.

*d.* The permittee has failed to pay the Title V permit fees.

*e.* The permittee has failed to pay an administrative, civil or criminal penalty imposed for violations of the permit.

**22.115(2)** If the director suspends, terminates or revokes a Title V permit under this rule, the notice of such action shall be served on the applicant or permittee by certified mail, return receipt requested.

The notice shall include a statement detailing the grounds for the action sought, and the proceeding shall in all other respects comply with the requirements of rule 561—7.16(17A,455A).

**567—22.116(455B) Title V permit renewals.**

**22.116(1)** An application for Title V permit renewal shall be subject to the same procedural requirements that apply to initial permit issuance, including those for public participation and review by the administrator and affected states.

**22.116(2)** Except as provided in rule 567—22.104(455B), permit expiration terminates a source's right to operate unless a timely and complete application for renewal has been submitted in accordance with rule 567—22.105(455B).

**567—22.117 to 22.119** Reserved.

**567—22.120(455B) Acid rain program—definitions.** The terms used in rules 567—22.120(455B) through 567—22.147(455B) shall have the meanings set forth in Title IV of the Clean Air Act, 42 U.S.C. 7401, et seq., as amended through November 15, 1990, and in this rule. The definitions set forth in 40 CFR Part 72 as amended through January 24, 2008, and 40 CFR Part 76 as amended through October 15, 1999, are adopted by reference.

“40 CFR Part 72,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 72, or the cited provision therein, as amended through January 24, 2008.

“40 CFR Part 73,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 73, or the cited provision therein, as amended through April 28, 2006.

“40 CFR Part 74,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 74, or the cited provision therein, as amended through April 28, 2006.

“40 CFR Part 75,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 75, or the cited provision therein, as amended through February 13, 2008.

“40 CFR Part 76,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 76, or the cited provision therein, as amended through October 15, 1999.

“40 CFR Part 77,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 77, or the cited provision therein, as amended through May 12, 2005.

“40 CFR Part 78,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 78, or the cited provision therein, as amended through April 28, 2006.

“*Acid rain permit*” means the legally binding written document, or portion of such document, issued by the department (following an opportunity for appeal as set forth in 561—Chapter 7, as adopted by reference at 567—Chapter 7), including any permit revisions, specifying the acid rain program requirements applicable to an affected source, to each affected unit at an affected source, and to the owner and operators and the designated representative of the affected source or the affected unit.

“*Department*” means the department of natural resources and is the state acid rain permitting authority.

“*Draft acid rain permit*” means the version of the acid rain permit, or the acid rain portion of a Title V operating permit, that the department offers for public comment.

“*Permit revision*” means a permit modification, fast-track modification, administrative permit amendment, or automatic permit amendment, as provided in rules 567—22.140(455B) through 567—22.144(455B).

“*Proposed acid rain permit*” means the version of the acid rain permit that the department submits to the Administrator after the public comment period, but prior to completion of the EPA permit review under 40 CFR 70.8(c) as amended through July 21, 1992.

“*Title V operating permit*” means a permit issued under rules 567—22.100(455B) through 567—22.116(455B) implementing Title V of the Act.

“*Ton*” or “*tonnage*” means any short ton (i.e., 2,000 pounds). For purposes of determining compliance with the acid rain emissions limitations and reduction requirements, total tons for a year shall be calculated as the sum of all recorded hourly emissions (or the tonnage equivalent of the

recorded hourly emissions) in accordance with rule 567—25.2(455B), with any remaining fraction of a ton equal to or greater than 0.50 ton deemed to equal one ton and any fraction of a ton less than 0.50 ton deemed not equal to a ton.

**567—22.121(455B) Measurements, abbreviations, and acronyms.** Measurements, abbreviations, and acronyms used in rules 567—22.120(455B) to 567—22.147(455B) are defined as follows:

“*ASTM*” means American Society for Testing and Materials.

“*Btu*” means British thermal unit.

“*CFR*” means Code of Federal Regulations.

“*DOE*” means Department of Energy.

“*EPA*” means Environmental Protection Agency.

“*mmBtu*” means million Btu.

“*MWe*” means megawatt electrical.

“*SO<sub>2</sub>*” means sulfur dioxide.

**567—22.122(455B) Applicability.**

**22.122(1)** Each of the following units shall be an affected unit, and any source that includes such a unit shall be an affected source, subject to the requirements of the acid rain program:

- a. A unit listed in Table 1 of 40 CFR 73.10(a).
- b. An existing unit that is identified in Table 2 or 3 of 40 CFR 73.10, and any other existing utility unit, except a unit under subrule 22.122(2).
- c. A utility unit, except a unit under subrule 22.122(2), that:
  - (1) Is a new unit;
  - (2) Did not serve a generator with a nameplate capacity greater than 25 MWe on November 15, 1990, but serves such a generator after November 15, 1990;
  - (3) Was a simple combustion turbine on November 15, 1990, but adds or uses auxiliary firing after November 15, 1990;
  - (4) Was an exempt cogeneration facility under paragraph 22.122(2)“*d*” but during any three-calendar-year period after November 15, 1990, sold, to a utility power distribution system, an annual average of more than one-third of its potential electrical output capacity and more than 219,000 MWe-hrs electric output, on a gross basis;
  - (5) Was an exempt qualifying facility under paragraph 22.122(2)“*e*” but, at any time after the later of November 15, 1990, or the date the facility commences commercial operation, fails to meet the definition of qualifying facility;
  - (6) Was an exempt independent power production facility under paragraph 22.122(2)“*f*” but, at any time after the later of November 15, 1990, or the date the facility commences commercial operation, fails to meet the definition of independent power production facility; or
  - (7) Was an exempt solid waste incinerator under paragraph 22.122(2)“*g*” but during any three-calendar-year period after November 15, 1990, consumes 20 percent or more (on a Btu basis) fossil fuel.
  - (8) Is a coal-fired substitution unit that is designated in a substitution plan that was not approved and not active as of January 1, 1995, or is a coal-fired compensating unit.

**22.122(2)** The following types of units are not affected units subject to the requirements of the acid rain program:

- a. A simple combustion turbine that commenced operation before November 15, 1990.
- b. Any unit that commenced commercial operation before November 15, 1990, and that did not, as of November 15, 1990, and does not currently, serve a generator with a nameplate capacity of greater than 25 MWe.
- c. Any unit that, during 1985, did not serve a generator that produced electricity for sale and that did not, as of November 15, 1990, and does not currently, serve a generator that produces electricity for sale.
- d. A cogeneration facility which:

(1) For a unit that commenced construction on or prior to November 15, 1990, was constructed for the purpose of supplying equal to or less than one-third its potential electrical output capacity or equal to or less than 219,000 MWe-hrs actual electric output on an annual basis to any utility power distribution system for sale (on a gross basis). If the purpose of construction is not known, it will be presumed to be consistent with the actual operation from 1985 through 1987. However, if in any three-calendar-year period after November 15, 1990, such unit sells to a utility power distribution system an annual average of more than one-third of its potential electrical output capacity and more than 219,000 MWe-hrs actual electric output (on a gross basis), that unit shall be an affected unit, subject to the requirements of the acid rain program; or

(2) For units that commenced construction after November 15, 1990, supplies equal to or less than one-third its potential electrical output capacity or equal to or less than 219,000 MWe-hrs actual electric output on an annual basis to any utility power distribution system for sale (on a gross basis). However, if in any three-calendar-year period after November 15, 1990, such unit sells to a utility power distribution system an annual average of more than one-third of its potential electrical output capacity and more than 219,000 MWe-hrs actual electric output (on a gross basis), that unit shall be an affected unit, subject to the requirements of the acid rain program.

*e.* A qualifying facility that:

(1) Has, as of November 15, 1990, one or more qualifying power purchase commitments to sell at least 15 percent of its total planned net output capacity; and

(2) Consists of one or more units designated by the owner or operator with total installed net output capacity not exceeding 130 percent of the total planned net output capacity. If the emissions rates of the units are not the same, the administrator may exercise discretion to designate which units are exempt.

*f.* An independent power production facility that:

(1) Has, as of November 15, 1990, one or more qualifying power purchase commitments to sell at least 15 percent of its total planned net output capacity; and

(2) Consists of one or more units designated by the owner or operator with total installed net output capacity not exceeding 130 percent of its total planned net output capacity. If the emissions rates of the units are not the same, the administrator may exercise discretion to designate which units are exempt.

*g.* A solid waste incinerator, if more than 80 percent (on a Btu basis) of the annual fuel consumed at such incinerator is other than fossil fuels. For a solid waste incinerator which began operation before January 1, 1985, the average annual fuel consumption of nonfossil fuels for calendar years 1985 through 1987 must be greater than 80 percent for such an incinerator to be exempt. For a solid waste incinerator which began operation after January 1, 1985, the average annual fuel consumption of nonfossil fuels for the first three years of operation must be greater than 80 percent for such an incinerator to be exempt. If, during any three-calendar-year period after November 15, 1990, such incinerator consumes 20 percent or more (on a Btu basis) fossil fuel, such incinerator will be an affected source under the acid rain program.

*h.* A nonutility unit.

**22.122(3)** A certifying official of any unit may petition the administrator for a determination of applicability under 40 CFR 72.6(c). The administrator's determination of applicability shall be binding upon the department, unless the petition is found to have contained significant errors or omissions.

**567—22.123(455B) Acid rain exemptions.**

**22.123(1)** *New unit exemption.* The new unit exemption, as specified in 40 CFR §72.7, except for 40 CFR §72.7(c)(1)(i), is adopted by reference. This exemption applies to new utility units.

**22.123(2)** *Retired unit exemption.* The retired unit exemption, as specified in 40 CFR §72.8, is adopted by reference. This exemption applies to any affected unit that is permanently retired.

**22.123(3)** *Industrial utility-unit exemption.* The industrial utility-unit exemption, as specified in 40 CFR §72.14, is adopted by reference. This exemption applies to any noncogeneration utility unit.

**567—22.124(455B) Retired units exemption.** Rescinded IAB 9/9/98, effective 10/14/98.

**567—22.125(455B) Standard requirements.****22.125(1) Permit requirements.**

*a.* The designated representative of each affected source and each affected unit at the source shall:

(1) Submit a complete acid rain permit application under this chapter in accordance with the deadlines specified in rule 567—22.128(455B);

(2) Submit in a timely manner any supplemental information that the department determines is necessary in order to review an acid rain permit application and issue or deny an acid rain permit.

*b.* The owners and operators of each affected source and each affected unit at the source shall:

(1) Operate the unit in compliance with a complete acid rain permit application or a superseding acid rain permit issued by the department; and

(2) Have an acid rain permit.

**22.125(2) Monitoring requirements.**

*a.* The owners and operators and, to the extent applicable, designated representative of each affected source and each affected unit at the source shall comply with the monitoring requirements as provided in rule 567—25.2(455B) and Section 407 of the Act and regulations implementing Section 407 of the Act.

*b.* The emissions measurements recorded and reported in accordance with rule 567—25.2(455B) and Section 407 of the Act and regulations implementing Section 407 of the Act shall be used to determine compliance by the unit with the acid rain emissions limitations and emissions reduction requirements for sulfur dioxide and nitrogen oxides under the acid rain program.

*c.* The requirements of rule 567—25.2(455B) and regulations implementing Section 407 of the Act shall not affect the responsibility of the owners and operators to monitor emissions of other pollutants or other emissions characteristics at the unit under other applicable requirements of the Act and other provisions of the operating permit for the source.

**22.125(3) Sulfur dioxide requirements.**

*a.* The owners and operators of each source and each affected unit at the source shall:

(1) Hold allowances, as of the allowance transfer deadline, in the unit's compliance subaccount (after deductions under 40 CFR 73.34(c)) not less than the total annual emissions of sulfur dioxide for the previous calendar year from the unit; and

(2) Comply with the applicable acid rain emissions limitation for sulfur dioxide.

*b.* Each ton of sulfur dioxide emitted in excess of the acid rain emissions limitations for sulfur dioxide shall constitute a separate violation of the Act.

*c.* An affected unit shall be subject to the requirements under paragraph 22.125(3) "a" as follows: starting January 1, 2000, an affected unit under paragraph 22.122(1) "b"; or starting on the later of January 1, 2000, or the deadline for monitor certification under rule 567—25.2(455B), an affected unit under paragraph 22.122(1) "c."

*d.* Allowances shall be held in, deducted from, or transferred among allowance tracking system accounts in accordance with the acid rain program.

*e.* An allowance shall not be deducted, in order to comply with the requirements under paragraph 22.125(3) "a," prior to the calendar year for which the allowance was allocated.

*f.* An allowance allocated by the administrator under the acid rain program is a limited authorization to emit sulfur dioxide in accordance with the acid rain program. No provision of the acid rain program, the acid rain permit application, the acid rain permit, or the written exemption under rules 567—22.123(455B) and 567—22.124(455B) and no provision of law shall be construed to limit the authority of the United States to terminate or limit such authorization.

*g.* An allowance allocated by the administrator under the acid rain program does not constitute a property right.

**22.125(4) Nitrogen oxides requirements.** The owners and operators of the source and each affected unit at the source shall comply with the applicable acid rain emission limitation for nitrogen oxides, as specified in 40 CFR Sections 76.5 and 76.7; 76.6; and 76.8, 76.11, 76.12, and 76.15; or by alternative emission limitations provided for by 40 CFR 76.10, as long as the alternative emission limitation has been petitioned and demonstrated according to 40 CFR 76.14 and approved by the department.

**22.125(5) Excess emissions requirements.**

a. The designated representative of an affected unit that has excess emissions in any calendar year shall submit a proposed offset plan to the administrator, as required under 40 CFR Part 77, and submit a copy to the department.

b. The owners and operators of an affected unit that has excess emissions in any calendar year shall:

(1) Pay to the administrator without demand the penalty required, and pay to the administrator upon demand the interest on that penalty, as required by 40 CFR Part 77; and

(2) Comply with the terms of an approved offset plan, as required by 40 CFR Part 77.

**22.125(6) Record-keeping and reporting requirements.**

a. Unless otherwise provided, the owners and operators of the source and each affected unit at the source shall keep on site at the source each of the following documents for a period of five years from the date the document is created. This period may be extended for cause, at any time prior to the end of five years, in writing by the administrator or the department.

(1) The certificate of representation for the designated representative for the source and each affected unit at the source and all documents that demonstrate the truth of the statements in the certificate of representation, in accordance with 40 CFR 72.24; provided that the certificate and documents shall be retained on site at the source beyond such five-year period until such documents are superseded because of the submission of a new certificate of representation changing the designated representative.

(2) All emissions monitoring information, in accordance with rule 567—25.2(455B).

(3) Copies of all reports, compliance certifications, and other submissions and all records made or required under the acid rain program.

(4) Copies of all documents used to complete an acid rain permit application and any other submission under the acid rain program or to demonstrate compliance with the requirements of the acid rain program.

b. The designated representative of an affected source and each affected unit at the source shall submit the reports and compliance certifications required under the acid rain program, including those under rules 567—22.146(455B) and 567—22.147(455B) and rule 567—25.2(455B).

**22.125(7) Liability.**

a. Any person who knowingly violates any requirement or prohibition of the acid rain program, a complete acid rain permit application, an acid rain permit, or a written exemption under rules 567—22.123(455B) or 567—22.124(455B), including any requirement for the payment of any penalty owed to the United States, shall be subject to enforcement by the administrator pursuant to Section 113(c) of the Act and by the department pursuant to Iowa Code section 455B.146.

b. Any person who knowingly makes a false, material statement in any record, submission, or report under the acid rain program shall be subject to criminal enforcement by the administrator pursuant to Section 113(c) of the Act and 18 U.S.C. 1001 and by the department pursuant to Iowa Code section 455B.146.

c. No permit revision shall excuse any violation of the requirements of the acid rain program that occurs prior to the date that the revision takes effect.

d. Each affected source and each affected unit shall meet the requirements of the acid rain program.

e. Any provision of the acid rain program that applies to an affected source (including a provision applicable to the designated representative of an affected source) shall also apply to the owners and operators of such source and of the affected units at the source.

f. Any provision of the acid rain program that applies to an affected unit (including a provision applicable to the designated representative of an affected unit) shall also apply to the owners and operators of such unit. Except as provided under rule 567—22.132(455B) (Phase II repowering extension plans), Section 407 of the Act and regulations implementing Section 407 of the Act, and except with regard to the requirements applicable to units with a common stack under rule 567—25.2(455B), the owners and operators and the designated representative of one affected unit shall not be liable for any violation by any other affected unit of which they are not owners or operators or

the designated representative and that is located at a source of which they are not owners or operators or the designated representative.

*g.* Each violation of a provision of rules 567—22.120(455B) to 567—22.146(455B) and 40 CFR Parts 72, 73, 75, 76, 77, and 78 and regulations implementing Sections 407 and 410 of the Act by an affected source or affected unit, or by an owner or operator or designated representative of such source or unit, shall be a separate violation of the Act.

**22.125(8) *Effect on other authorities.*** No provision of the acid rain program, an acid rain permit application, an acid rain permit, or a written exemption under rule 567—22.123(455B) or 567—22.124(455B) shall be construed as:

*a.* Except as expressly provided in Title IV of the Act, exempting or excluding the owners and operators and, to the extent applicable, the designated representative of an affected source or affected unit from compliance with any other provision of the Act, including the provisions of Title I of the Act relating to applicable National Ambient Air Quality Standards or State Implementation Plans;

*b.* Limiting the number of allowances a unit can hold; provided that the number of allowances held by the unit shall not affect the source's obligation to comply with any other provisions of the Act;

*c.* Requiring a change of any kind in any state law regulating electric utility rates and charges, affecting any state law regarding such state rule, or limiting such state rule, including any prudence review requirements under such state law;

*d.* Modifying the Federal Power Act or affecting the authority of the Federal Energy Regulatory Commission under the Federal Power Act; or

*e.* Interfering with or impairing any program for competitive bidding for power supply in a state in which such program is established.

**567—22.126(455B) Designated representative—submissions.**

**22.126(1)** The designated representative shall submit a certificate of representation, and any superseding certificate of representation, to the administrator in accordance with Subpart B of 40 CFR Part 72, and, concurrently, shall submit a copy to the department. Whenever the term “designated representative” is used in this rule, the term shall be construed to include the alternate designated representative.

**22.126(2)** Each submission under the acid rain program shall be submitted, signed, and certified by the designated representative for all sources on behalf of which the submission is made.

**22.126(3)** In each submission under the acid rain program, the designated representative shall certify by signature:

*a.* The following statement, which shall be included verbatim in such submission: “I am authorized to make this submission on behalf of the owners and operators of the affected source or affected units for which the submission is made.”

*b.* The following statement, which shall be included verbatim in such submission: “I certify under penalty of law that I have personally examined, and am familiar with, the statements and information submitted in this document and all its attachments. Based on my inquiry of those individuals with primary responsibility for obtaining the information, I certify that the statements and information are to the best of my knowledge and belief true, accurate, and complete. I am aware that there are significant penalties for submitting false statements and information or omitting required statements and information, including the possibility of fine or imprisonment.”

**22.126(4)** The department will accept or act on a submission made on behalf of owners or operators of an affected source and an affected unit only if the submission has been made, signed, and certified in accordance with subrules 22.126(2) and 22.126(3).

**22.126(5)** The designated representative of a source shall serve notice on each owner and operator of the source and of an affected unit at the source:

*a.* By the date of submission, of any acid rain program submissions by the designated representative;

*b.* Within ten business days of receipt of a determination, of any written determination by the administrator or the department; and

*c.* Provided that the submission or determination covers the source or the unit.

**22.126(6)** The designated representative of a source shall provide each owner and operator of an affected unit at the source a copy of any submission or determination under subrule 22.126(5), unless the owner or operator expressly waives the right to receive such a copy.

**567—22.127(455B) Designated representative—objections.**

**22.127(1)** Except as provided in 40 CFR 72.23, no objection or other communication submitted to the administrator or the department concerning the authorization, or any submission, action or inaction, of the designated representative shall affect any submission, action, or inaction of the designated representative, or the finality of any decision by the department, under the acid rain program. In the event of such communication, the department is not required to stay any submission or the effect of any action or inaction under the acid rain program.

**22.127(2)** The department will not adjudicate any private legal dispute concerning the authorization or any submission, action, or inaction of any designated representative, including private legal disputes concerning the proceeds of allowance transfers.

**567—22.128(455B) Acid rain applications—requirement to apply.**

**22.128(1) *Duty to apply.*** The designated representative of any source with an affected unit shall submit a complete acid rain permit application by the applicable deadline in subrules 22.128(2) and 22.128(3), and the owners and operators of such source and any affected unit at the source shall not operate the source or unit without a permit that states its acid rain program requirements.

**22.128(2) *Deadlines.***

*a.* For any source with an existing unit described under paragraph 22.122(1)“*b*,” the designated representative shall submit a complete acid rain permit application governing such unit to the department on or before January 1, 1996.

*b.* For any source with a new unit described under subparagraph 22.122(1)“*c*”(1), the designated representative shall submit a complete acid rain permit application governing such unit to the department at least 24 months before the later of January 1, 2000, or the date on which the unit commences operation.

*c.* For any source with a unit described under subparagraph 22.122(1)“*c*”(2), the designated representative shall submit a complete acid rain permit application governing such unit to the department at least 24 months before the later of January 1, 2000, or the date on which the unit begins to serve a generator with a nameplate capacity greater than 25 MWe.

*d.* For any source with a unit described under subparagraph 22.122(1)“*c*”(3), the designated representative shall submit a complete acid rain permit application governing such unit to the department at least 24 months before the later of January 1, 2000, or the date on which the auxiliary firing commences operation.

*e.* For any source with a unit described under subparagraph 22.122(1)“*c*”(4), the designated representative shall submit a complete acid rain permit application governing such unit to the department before the later of January 1, 1998, or March 1 of the year following the three-calendar-year period in which the unit sold to a utility power distribution system an annual average of more than one-third of its potential electrical output capacity and more than 219,000 MWe-hrs actual electric output (on a gross basis).

*f.* For any source with a unit described under subparagraph 22.122(1)“*c*”(5), the designated representative shall submit a complete acid rain permit application governing such unit to the department before the later of January 1, 1998, or March 1 of the year following the calendar year in which the facility fails to meet the definition of qualifying facility.

*g.* For any source with a unit described under subparagraph 22.122(1)“*c*”(6), the designated representative shall submit a complete acid rain permit application governing such unit to the department before the later of January 1, 1998, or March 1 of the year following the calendar year in which the facility fails to meet the definition of an independent power production facility.

*h.* For any source with a unit described under subparagraph 22.122(1)“*c*”(7), the designated representative shall submit a complete acid rain permit application governing such unit to the department

before the later of January 1, 1998, or March 1 of the year following the three-calendar-year period in which the incinerator consumed 20 percent or more fossil fuel (on a Btu basis).

*i.* For a Phase II unit with a Group 1 or a Group 2 boiler, the designated representative shall submit a complete permit application and compliance plan for NO<sub>x</sub> emissions to the department no later than January 1, 1998.

**22.128(3) *Duty to reapply.*** The designated representative shall submit a complete acid rain permit application for each source with an affected unit at least six months prior to the expiration of an existing acid rain permit governing the unit.

**22.128(4) *Submission of copies.*** The original and three copies of all permit applications shall be presented or mailed to the Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324.

[ARC 8215B, IAB 10/7/09, effective 11/11/09]

**567—22.129(455B) Information requirements for acid rain permit applications.** A complete acid rain permit application shall be submitted on a form approved by the department, which includes the following elements:

**22.129(1)** Identification of the affected source for which the permit application is submitted;

**22.129(2)** Identification of each affected unit at the source for which the permit application is submitted;

**22.129(3)** A complete compliance plan for each unit, in accordance with rules 567—22.131(455B) and 567—22.132(455B);

**22.129(4)** The standard requirements under rule 567—22.125(455B); and

**22.129(5)** If the unit is a new unit, the date that the unit has commenced or will commence operation and the deadline for monitor certification.

**567—22.130(455B) Acid rain permit application shield and binding effect of permit application.**

**22.130(1)** Once a designated representative submits a timely and complete acid rain permit application, the owners and operators of the affected source and the affected units covered by the permit application shall be deemed in compliance with the requirement to have an acid rain permit under paragraph 22.125(1) “b” and subrule 22.128(1); provided that any delay in issuing an acid rain permit is not caused by the failure of the designated representative to submit in a complete and timely fashion supplemental information, as required by the department, necessary to issue a permit.

**22.130(2)** Prior to the date on which an acid rain permit is issued as a final agency action subject to judicial review, an affected unit governed by and operated in accordance with the terms and requirements of a timely and complete acid rain permit application shall be deemed to be operating in compliance with the acid rain program.

**22.130(3)** A complete acid rain permit application shall be binding on the owners and operators and the designated representative of the affected source and the affected units covered by the permit application and shall be enforceable as an acid rain permit from the date of submission of the permit application until the issuance or denial of such permit as a final agency action subject to judicial review.

**567—22.131(455B) Acid rain compliance plan and compliance options—general.**

**22.131(1)** For each affected unit included in an acid rain permit application, a complete compliance plan shall include:

*a.* For sulfur dioxide emissions, a certification that, as of the allowance transfer deadline, the designated representative will hold allowances in the unit’s compliance subaccount (after deductions under 40 CFR 73.34(c)) not less than the total annual emissions of sulfur dioxide from the unit. The compliance plan may also specify, in accordance with rule 567—22.131(455B), one or more of the acid rain compliance options.

*b.* For nitrogen oxides emissions, a certification that the unit will comply with the applicable limitation established by subrule 22.125(4) or shall specify one or more acid rain compliance options, in accordance with Section 407 of the Act, and 40 CFR Section 76.9.

**22.131(2)** The compliance plan may include a multiunit compliance option under rule 567—22.132(455B) or Section 407 of the Act or regulations implementing Section 407.

*a.* A plan for a compliance option that includes units at more than one affected source shall be complete only if:

(1) Such plan is signed and certified by the designated representative for each source with an affected unit governed by such plan; and

(2) A complete permit application is submitted covering each unit governed by such plan.

*b.* The department's approval of a plan under paragraph 22.131(2) "a" that includes units in more than one state shall be final only after every permitting authority with jurisdiction over any such unit has approved the plan with the same modifications or conditions, if any.

**22.131(3)** Conditional approval. In the compliance plan, the designated representative of an affected unit may propose, in accordance with rules 567—22.131(455B) and 567—22.132(455B), any acid rain compliance option for conditional approval; provided that an acid rain compliance option under Section 407 of the Act may be conditionally proposed only to the extent provided in regulations implementing Section 407 of the Act.

*a.* To activate a conditionally approved acid rain compliance option, the designated representative shall notify the department in writing that the conditionally approved compliance option will actually be pursued beginning January 1 of a specified year. If the conditionally approved compliance option includes a plan described in paragraph 22.131(2) "a," the designated representative of each source governed by the plan shall sign and certify the notification. Such notification shall be subject to the limitations on activation under rule 567—22.132(455B) and regulations implementing Section 407 of the Act.

*b.* The notification under paragraph 22.131(3) "a" shall specify the first calendar year and the last calendar year for which the conditionally approved acid rain compliance option is to be activated. A conditionally approved compliance option shall be activated, if at all, before the date of any enforceable milestone applicable to the compliance option. The date of activation of the compliance option shall not be a defense against failure to meet the requirements applicable to that compliance option during each calendar year for which the compliance option is activated.

*c.* Upon submission of a notification meeting the requirements of paragraphs 22.131(3) "a" and "b," the conditionally approved acid rain compliance option becomes binding on the owners and operators and the designated representative of any unit governed by the conditionally approved compliance option.

*d.* A notification meeting the requirements of paragraphs 22.131(3) "a" and "b" will revise the unit's permit in accordance with rule 567—22.143(455B) (administrative permit amendment).

**22.131(4)** Termination of compliance option.

*a.* The designated representative for a unit may terminate an acid rain compliance option by notifying the department in writing that an approved compliance option will be terminated beginning January 1 of a specified year. Such notification shall be subject to the limitations on termination under rule 567—22.132(455B) and regulations implementing Section 407 of the Act. If the compliance option includes a plan described in paragraph 22.131(2) "a," the designated representative for each source governed by the plan shall sign and certify the notification.

*b.* The notification under paragraph 22.131(4) "a" shall specify the calendar year for which the termination will take effect.

*c.* Upon submission of a notification meeting the requirements of paragraphs 22.131(4) "a" and "b," the termination becomes binding on the owners and operators and the designated representative of any unit governed by the acid rain compliance option to be terminated.

*d.* A notification meeting the requirements of paragraphs 22.131(4) "a" and "b" will revise the unit's permit in accordance with rule 567—22.143(455B) (administrative permit amendment).

**567—22.132(455B) Repowering extensions.** Rescinded IAB 4/8/98, effective 5/13/98.

**567—22.133(455B) Acid rain permit contents—general.**

**22.133(1)** Each acid rain permit (including any draft acid rain permit) will contain the following elements:

- a. All elements required for a complete acid rain permit application under rule 567—22.129(455B), as approved or adjusted by the department;
- b. The applicable acid rain emissions limitation for sulfur dioxide; and
- c. The applicable acid rain emissions limitation for nitrogen oxides.

**22.133(2)** Each acid rain permit is deemed to incorporate the definitions of terms under rule 567—22.120(455B).

**567—22.134(455B) Acid rain permit shield.** Each affected unit operated in accordance with the acid rain permit that governs the unit and that was issued in compliance with Title IV of the Act, as provided in rules 567—22.120(455B) to 567—22.146(455B), rule 567—25.2(455B), or 40 CFR Parts 72, 73, 75, 76, 77, and 78, and the regulations implementing Section 407 of the Act, shall be deemed to be operating in compliance with the acid rain program, except as provided in paragraph 22.125(7) “f.”

**567—22.135(455B) Acid rain permit issuance procedures—general.** The department will issue or deny all acid rain permits in accordance with rules 567—22.100(455B) to 567—22.116(455B), including the completeness determination, draft permit, administrative record, statement of basis, public notice and comment period, public hearing, proposed permit, permit issuance, permit revision, and appeal procedures as amended by rules 567—22.135(455B) to 567—22.145(455B).

**567—22.136(455B) Acid rain permit issuance procedures—completeness.** The department will submit a written notice of application completeness to the administrator within ten working days following a determination by the department that the acid rain permit application is complete.

**567—22.137(455B) Acid rain permit issuance procedures—statement of basis.**

**22.137(1)** The statement of basis will briefly set forth significant factual, legal, and policy considerations on which the department relied in issuing or denying the draft acid rain permit.

**22.137(2)** The statement of basis will include the reasons, and supporting authority, for approval or disapproval of any compliance options requested in the permit application, including references to applicable statutory or regulatory provisions and to the administrative record.

**22.137(3)** The department will submit to the administrator a copy of the draft acid rain permit and the statement of basis and all other relevant portions of the Title V operating permit that may affect the draft acid rain permit.

**567—22.138(455B) Issuance of acid rain permits.**

**22.138(1)** Proposed permit. After the close of the public comment and EPA 45-day review period (pursuant to subrules 22.107(6) and 22.107(7)), the department will address any objections by the administrator, incorporate all necessary changes and issue or deny the acid rain permit.

**22.138(2)** The department will submit the proposed acid rain permit or denial of a proposed acid rain permit to the administrator in accordance with rules 567—22.100(455B) to 567—22.116(455B), the provisions of which shall be treated as applying to the issuance or denial of a proposed acid rain permit.

**22.138(3)** Following the administrator’s review of the proposed acid rain permit or denial of a proposed acid rain permit, the department, or under 40 CFR 70.8(c) as amended to July 21, 1992, the administrator, will incorporate any required changes and issue or deny the acid rain permit in accordance with rules 567—22.133(455B) and 567—22.134(455B).

**22.138(4)** No acid rain permit including a draft or proposed permit shall be issued unless the administrator has received a certificate of representation for the designated representative of the source in accordance with Subpart B of 40 CFR Part 72.

**22.138(5)** Permit issuance deadline and effective date.

*a.* On or before December 31, 1997, the department will issue an acid rain permit to each affected source whose designated representative submitted a timely and complete acid rain permit application by January 1, 1996, in accordance with rule 567—22.126(455B) and meets the requirements of rules 567—22.135(455B) to 567—22.139(455B) and rules 567—22.100(455B) to 567—22.116(455B).

*b.* Nitrogen oxides. Not later than January 1, 1999, the department will reopen the acid rain permit to add the acid rain program nitrogen oxides requirements; provided that the designated representative of the affected source submitted a timely and complete acid rain permit application for nitrogen oxides in accordance with rule 567—22.126(455B). Such reopening shall not affect the term of the acid rain portion of a Title V operating permit.

*c.* Each acid rain permit issued in accordance with paragraph 22.138(5) “*a*” shall take effect by the later of January 1, 2000, or, where the permit governs a unit under paragraph 22.122(1) “*c*,” the deadline for monitor certification under rule 567—25.2(455B).

*d.* Each acid rain permit shall have a term of five years commencing on its effective date.

*e.* An acid rain permit shall be binding on any new owner or operator or designated representative of any source or unit governed by the permit.

**22.138(6)** Each acid rain permit shall contain all applicable acid rain requirements, shall be a portion of the Title V operating permit that is complete and segregable from all other air quality requirements, and shall not incorporate information contained in any other documents, other than documents that are readily available.

**22.138(7)** Invalidation of the acid rain portion of a Title V operating permit shall not affect the continuing validity of the rest of the Title V operating permit, nor shall invalidation of any other portion of the Title V operating permit affect the continuing validity of the acid rain portion of the permit.

#### **567—22.139(455B) Acid rain permit appeal procedures.**

**22.139(1)** Appeals of the acid rain portion of a Title V operating permit issued by the department that do not challenge or involve decisions or actions of the administrator under 40 CFR Parts 72, 73, 75, 76, 77, and 78 and Sections 407 and 410 of the Act and regulations implementing Sections 407 and 410 shall be conducted according to the procedures in Iowa Code chapter 17A and 561—Chapter 7, as adopted by reference at 567—Chapter 7. Appeals of the acid rain portion of such a permit that challenge or involve such decisions or actions of the administrator shall follow the procedures under 40 CFR Part 78 and Section 307 of the Act. Such decisions or actions include, but are not limited to, allowance allocations, determinations concerning alternative monitoring systems, and determinations of whether a technology is a qualifying repowering technology.

**22.139(2)** No administrative appeal or judicial appeal of the acid rain portion of a Title V operating permit shall be allowed more than 30 days following respective issuance of the acid rain portion of the permit that is subject to administrative appeal or issuance of the final agency action subject to judicial appeal.

**22.139(3)** The administrator may intervene as a matter of right in any state administrative appeal of an acid rain permit or denial of an acid rain permit.

**22.139(4)** No administrative appeal concerning an acid rain requirement shall result in a stay of the following requirements:

*a.* The allowance allocations for any year during which the appeal proceeding is pending or is being conducted;

*b.* Any standard requirement under rule 567—22.125(455B);

*c.* The emissions monitoring and reporting requirements applicable to the affected units at an affected source under rule 567—25.2(455B);

*d.* Uncontested provisions of the decision on appeal; and

*e.* The terms of a certificate of representation submitted by a designated representative under Subpart B of 40 CFR Part 72.

**22.139(5)** The department will serve written notice on the administrator of any state administrative or judicial appeal concerning an acid rain provision of any Title V operating permit or denial of an acid rain portion of any Title V operating permit within 30 days of the filing of the appeal.

**22.139(6)** The department will serve written notice on the administrator of any determination or order in a state administrative or judicial proceeding that interprets, modifies, voids, or otherwise relates to any portion of an acid rain permit. Following any such determination or order, the administrator will have an opportunity to review and veto the acid rain permit or revoke the permit for cause in accordance with subrules 22.107(7) and 22.107(8).

**567—22.140(455B) Permit revisions—general.**

**22.140(1)** Rules 567—22.140(455B) to 567—22.145(455B) shall govern revisions to any acid rain permit issued by the department.

**22.140(2)** A permit revision may be submitted for approval at any time. No permit revision shall affect the term of the acid rain permit to be revised. No permit revision shall excuse any violation of an acid rain program requirement that occurred prior to the effective date of the revision.

**22.140(3)** The terms of the acid rain permit shall apply while the permit revision is pending.

**22.140(4)** Any determination or interpretation by the state (including the department or a state court) modifying or voiding any acid rain permit provision shall be subject to review by the administrator in accordance with 40 CFR 70.8(c) as amended to July 21, 1992, as applied to permit modifications, unless the determination or interpretation is an administrative amendment approved in accordance with rule 567—22.143(455B).

**22.140(5)** The standard requirements of rule 567—22.125(455B) shall not be modified or voided by a permit revision.

**22.140(6)** Any permit revision involving incorporation of a compliance option that was not submitted for approval and comment during the permit issuance process, or involving a change in a compliance option that was previously submitted, shall meet the requirements for applying for such compliance option under rule 567—22.132(455B) and Section 407 of the Act and regulations implementing Section 407 of the Act.

**22.140(7)** For permit revisions not described in rules 567—22.141(455B) and 567—22.142(455B), the department may, in its discretion, determine which of these rules is applicable.

**567—22.141(455B) Permit modifications.**

**22.141(1)** Permit modifications shall follow the permit issuance requirements of rules 567—22.135(455B) to 567—22.139(455B) and subrules 22.113(2) and 22.113(3).

**22.141(2)** For purposes of applying subrule 22.141(1), a permit modification shall be treated as an acid rain permit application, to the extent consistent with rules 567—22.140(455B) to 567—22.145(455B).

**22.141(3)** The following permit revisions are permit modifications:

*a.* Relaxation of an excess emission offset requirement after approval of the offset plan by the administrator;

*b.* Incorporation of a final nitrogen oxides alternative emissions limitation following a demonstration period;

*c.* Determinations concerning failed repowering projects under subrule 22.132(6); and

*d.* At the option of the designated representative submitting the permit revision, the permit revisions listed in subrule 22.142(2).

**567—22.142(455B) Fast-track modifications.**

**22.142(1)** Fast-track modifications shall follow the following procedures:

*a.* The designated representative shall serve a copy of the fast-track modification on the administrator, the department, and any person entitled to a written notice under subrules 22.107(6) and 22.107(7). Within five business days of serving such copies, the designated representative shall also give public notice by publication in a newspaper of general circulation in the area where the source is located or in a state publication designed to give general public notice.

*b.* The public shall have a period of 30 days, commencing on the date of publication of the notice, to comment on the fast-track modification. Comments shall be submitted in writing to the air quality bureau of the department and to the designated representative.

*c.* The designated representative shall submit the fast-track modification to the department on or before commencement of the public comment period.

*d.* Within 30 days of the close of the public comment period, the department will consider the fast-track modification and the comments received and approve, in whole or in part or with changes or conditions as appropriate, or disapprove the modification. A fast-track modification shall be effective immediately upon issuance, in accordance with subrule 22.113(2) as applied to significant modifications.

**22.142(2)** The following permit revisions are, at the option of the designated representative submitting the permit revision, either fast-track modifications under this rule or permit modifications under rule 567—22.141(455B):

*a.* Incorporation of a compliance option that the designated representative did not submit for approval and comment during the permit issuance process;

*b.* Addition of a nitrogen oxides averaging plan to a permit; and

*c.* Changes in a repowering plan, nitrogen oxides averaging plan, or nitrogen oxides compliance deadline extension.

**567—22.143(455B) Administrative permit amendment.**

**22.143(1)** Administrative amendments shall follow the procedures set forth at rule 567—22.111(455B). The department will submit the revised portion of the permit to the administrator within ten working days after the date of final action on the request for an administrative amendment.

**22.143(2)** The following permit revisions are administrative amendments:

*a.* Activation of a compliance option conditionally approved by the department; provided that all requirements for activation under subrule 22.131(3) and rule 567—22.132(455B) are met;

*b.* Changes in the designated representative or alternative designated representative; provided that a new certificate of representation is submitted to the administrator in accordance with Subpart B of 40 CFR Part 72;

*c.* Correction of typographical errors;

*d.* Changes in names, addresses, or telephone or facsimile numbers;

*e.* Changes in the owners or operators; provided that a new certificate of representation is submitted within 30 days to the administrator and the department in accordance with Subpart B of 40 CFR Part 72;

*f.* Termination of a compliance option in the permit; provided that all requirements for termination under subrule 22.131(4) shall be met and this procedure shall not be used to terminate a repowering plan after December 31, 1999;

*g.* Changes in the date, specified in a new unit's acid rain permit, of commencement of operation or the deadline for monitor certification; provided that they are in accordance with rule 567—22.125(455B);

*h.* The addition of or change in a nitrogen oxides alternative emissions limitation demonstration period; provided that the requirements of regulations implementing Section 407 of the Act are met; and

*i.* Incorporation of changes that the administrator has determined to be similar to those in paragraphs "a" through "h" of this subrule.

**567—22.144(455B) Automatic permit amendment.** The following permit revisions shall be deemed to amend automatically, and become a part of the affected unit's acid rain permit by operation of law without any further review:

**22.144(1)** Upon recordation by the administrator under 40 CFR Part 73, all allowance allocations to, transfers to, and deductions from an affected unit's allowance tracking system account; and

**22.144(2)** Incorporation of an offset plan that has been approved by the administrator under 40 CFR Part 77.

**567—22.145(455B) Permit reopenings.**

**22.145(1)** As provided in rule 567—22.114(455B), the department will reopen an acid rain permit for cause, including whenever additional requirements become applicable to any affected unit governed by the permit.

**22.145(2)** In reopening an acid rain permit for cause, the department will issue a draft permit changing the provisions, or adding the requirements, for which the reopening was necessary. The draft permit shall be subject to the requirements of rules 567—22.135(455B) to 567—22.139(455B).

**22.145(3)** Any reopening of an acid rain permit shall not affect the term of the permit.

**567—22.146(455B) Compliance certification—annual report.**

**22.146(1)** Applicability and deadline. For each calendar year in which a unit is subject to the acid rain emissions limitations, the designated representative of the source at which the unit is located shall submit to the administrator and the department, within 60 days after the end of the calendar year, an annual compliance certification report for the unit in compliance with 40 CFR 72.90.

**22.146(2)** The submission of complete compliance certifications in accordance with subrule 22.146(1) and rule 567—25.2(455B) shall be deemed to satisfy the requirement to submit compliance certifications under paragraph 22.108(15) “e” with regard to the acid rain portion of the source’s Title V operating permit.

**567—22.147(455B) Compliance certification—units with repowering extension plans.** Rescinded IAB 4/8/98, effective 5/13/98.

**567—22.148(455B) Sulfur dioxide opt-ins.** The department adopts by reference the provisions of 40 CFR Part 74, Acid Rain Opt-Ins.

**567—22.149 to 22.199** Reserved.

**567—22.200(455B) Definitions for voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.201(455B) Eligibility for voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.202(455B) Requirement to have a Title V permit.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.203(455B) Voluntary operating permit applications.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.204(455B) Voluntary operating permit fees.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.205(455B) Voluntary operating permit processing procedures.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.206(455B) Permit content.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.207(455B) Relation to construction permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.208(455B) Suspension, termination, and revocation of voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.209(455B) Change of ownership for facilities with voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.210 to 22.299** Reserved.

**567—22.300(455B) Operating permit by rule for small sources.** Except as provided in subrule 22.300(11), any source which otherwise would be required to obtain a Title V operating permit may instead register for an operation permit by rule for small sources. Sources which comply with the requirements contained in this rule will be deemed to have an operating permit by rule for small sources. Sources which comply with this rule will be considered to have federally enforceable limits so that their potential emissions are less than the major source thresholds for regulated air pollutants and hazardous air pollutants as defined in rule 567—22.100(455B).

**22.300(1) Definitions for operating permit by rule for small sources.** For the purposes of rule 567—22.300(455B), the definitions shall be the same as the definitions found at rule 567—22.100(455B).

**22.300(2) Registration for operating permit by rule for small sources.**

*a.* Except as provided in subrules 22.300(3) and 22.300(11), any person who owns or operates a stationary source and meets the following criteria may register for an operating permit by rule for small sources:

(1) The potential to emit air contaminants is equal to or in excess of the threshold for a major stationary source of regulated air pollutants or hazardous air pollutants, and

(2) For every 12-month rolling period, the actual emissions of the stationary source are less than or equal to the emission limitations specified in subrule 22.300(6).

*b.* Eligibility for an operating permit by rule for small sources does not eliminate the source's responsibility to meet any and all applicable federal requirements including, but not limited to, a maximum achievable control technology (MACT) standard.

*c.* Nothing in this rule shall prevent any stationary source which has had a Title V operating permit from qualifying to comply with this rule in the future in lieu of maintaining an application for a Title V operating permit or upon rescission of a Title V operating permit if the owner or operator demonstrates that the stationary source is in compliance with the emissions limitations in subrule 22.300(6).

*d.* The department reserves the right to require proof that the expected emissions from the stationary source, in conjunction with all other emissions, will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28.

**22.300(3) Exceptions to eligibility.**

*a.* Any affected source subject to the provisions of Title IV of the Act or any solid waste incinerator unit required to obtain a Title V operating permit under Section 129(e) of the Act is not eligible for an operating permit by rule for small sources.

*b.* Sources which meet the registration criteria established in 22.300(2)“*a*” and meet all applicable requirements of rule 567—22.300(455B), and are subject to a standard or other requirement under 567—subrule 23.1(2) (standards of performance for new stationary sources) or Section 111 of the Act are eligible for an operating permit by rule for small sources. These sources shall be required to obtain a Title V operating permit when the exemptions specified in subrule 22.102(1) or 22.102(2) no longer apply.

*c.* Sources which meet the registration criteria established in 22.300(2)“*a*” and meet all applicable requirements of rule 567—22.300(455B), and are subject to a standard or other requirement under 567—subrule 23.1(3) (emissions standards for hazardous air pollutants), 567—subrule 23.1(4) (emissions standards for hazardous air pollutants for source categories) or Section 112 of the Act are eligible for an operating permit by rule for small sources. These sources shall be required to obtain a Title V operating permit when the exemptions specified in subrule 22.102(1) or 22.102(2) no longer apply.

**22.300(4) Stationary source with de minimus emissions.** Stationary sources with de minimus emissions must submit the standard registration form and must meet and fulfill all registration and reporting requirements as found in 22.300(8). Only the record-keeping and reporting provisions listed

in 22.300(4) “b” shall apply to a stationary source with de minimus emissions or operations as specified in 22.300(4) “a”:

*a. De minimus emission and usage limits.* For the purpose of this rule a stationary source with de minimus emissions means:

(1) In every 12-month rolling period, the stationary source emits less than or equal to the following quantities of emissions:

1. 5 tons per year of a regulated air pollutant (excluding HAPs), and
2. 2 tons per year of a single HAP, and
3. 5 tons per year of any combination of HAPs.

(2) In every 12-month rolling period, at least 90 percent of the stationary source’s emissions are associated with an operation for which the throughput is less than or equal to one of the quantities specified in paragraphs “1” to “9” below:

1. 1,400 gallons of any combination of solvent-containing materials but no more than 550 gallons of any one solvent-containing material, provided that the materials do not contain the following: methyl chloroform (1,1,1-trichloroethane), methylene chloride (dichloromethane), tetrachloroethylene (perchloroethylene), or trichloroethylene;

2. 750 gallons of any combination of solvent-containing materials where the materials contain the following: methyl chloroform (1,1,1-trichloroethane), methylene chloride (dichloromethane), tetrachloroethylene (perchloroethylene), or trichloroethylene, but not more than 300 gallons of any one solvent-containing material;

3. 365 gallons of solvent-containing material used at a paint spray unit(s);

4. 4,400,000 gallons of gasoline dispensed from equipment with Phase I and II vapor recovery systems;

5. 470,000 gallons of gasoline dispensed from equipment without Phase I and II vapor recovery systems;

6. 1,400 gallons of gasoline combusted;

7. 16,600 gallons of diesel fuel combusted;

8. 500,000 gallons of distillate oil combusted; or

9. 71,400,000 cubic feet of natural gas combusted.

*b. Record keeping for de minimis sources.* Upon registration with the department the owner or operator of a stationary source eligible to register for an operating permit by rule for small sources shall comply with all applicable record-keeping requirements of this rule. The record-keeping requirements of this rule shall not replace any record-keeping requirement contained in a construction permit or in a local, state, or federal rule or regulation.

(1) De minimis sources shall always maintain an annual log of each raw material used and its amount. The annual log and all related material safety data sheets (MSDS) for all materials shall be maintained for a period of not less than the most current five years. The annual log will begin on the date the small source operating permit application is submitted, then on an annual basis, based on a calendar year.

(2) Within 30 days of a written request by the state or the U.S. EPA, the owner or operator of a stationary source not maintaining records pursuant to subrule 22.300(7) shall demonstrate that the stationary source’s emissions or throughput is not in excess of the applicable quantities set forth in paragraph “a” above.

**22.300(5) Provision for air pollution control equipment.** The owner or operator of a stationary source may take into account the operation of air pollution control equipment on the capacity of the source to emit an air contaminant if the equipment is required by federal, state, or local air pollution control agency rules and regulations or permit terms and conditions that are federally enforceable. The owner or operator of the stationary source shall maintain and operate such air pollution control equipment in a manner consistent with good air pollution control practice for minimizing emissions.

**22.300(6) Emission limitations.**

*a.* No stationary source subject to this rule shall emit in every 12-month rolling period more than the following quantities of emissions:

(1) 50 percent of the major source thresholds for regulated air pollutants (excluding hazardous air pollutants), and

(2) 5 tons per year of a single hazardous air pollutant, and

(3) 12.5 tons per year of any combination of hazardous air pollutants.

*b.* The owner or operator of a stationary source subject to this rule shall obtain any necessary permits prior to commencing any physical or operational change or activity which will result in actual emissions that exceed the limits specified in paragraph “*a*” of this subrule.

**22.300(7) Record-keeping requirements for non-de minimis sources.** Upon registration with the department the owner or operator of a stationary source eligible to register for an operating permit by rule for small stationary sources shall comply with all applicable record-keeping requirements in this rule. The record-keeping requirements of this rule shall not replace any record-keeping requirement contained in any operating permit, a construction permit, or in a local, state, or federal rule or regulation.

*a.* A stationary source previously covered by the provisions in 22.300(4) shall comply with the applicable provisions of subrule 22.300(7) (record-keeping requirements) and subrule 22.300(8) (reporting requirements) if the stationary source exceeds the quantities specified in paragraph 22.300(4) “*a*.”

*b.* The owner or operator of a stationary source subject to this rule shall keep and maintain records, as specified in 22.300(7) “*c*” below, for each permitted emission unit and each piece of emission control equipment sufficient to determine actual emissions. Such information shall be maintained on site for five years, and be made available to local, state, or U.S. EPA staff upon request.

*c.* Record-keeping requirements for emission units and emission control equipment. Record-keeping requirements for emission units are specified below in 22.300(7) “*c*”(1) through 22.300(7) “*c*”(4). Record-keeping requirements for emission control equipment are specified in 22.300(7) “*c*”(5).

(1) Coating/solvent emission unit. The owner or operator of a stationary source subject to this rule that contains a coating/solvent emission unit not permitted under 22.8(1) (permit by rule for spray booths) or uses a coating, solvent, ink or adhesive shall keep and maintain the following records:

1. A current list of all coatings, solvents, inks and adhesives in use. This list shall include: material safety data sheets (MSDS), manufacturer’s product specifications, and material VOC content reports for each solvent (including solvents used in cleanup and surface preparation), coating, ink, and adhesive used showing at least the product manufacturer, product name and code, VOC and hazardous air pollutant content;

2. A description of any equipment used during and after coating/solvent application, including type, make and model; maximum design process rate or throughput; and control device(s) type and description (if any);

3. A monthly log of the consumption of each solvent (including solvents used in cleanup and surface preparation), coating, ink, and adhesive used; and

4. All purchase orders, invoices, and other documents to support information in the monthly log.

(2) Organic liquid storage unit. The owner or operator of a stationary source subject to this rule that contains an organic liquid storage unit shall keep and maintain the following records:

1. A monthly log identifying the liquid stored and monthly throughput; and

2. Information on the tank design and specifications including control equipment.

(3) Combustion emission unit. The owner or operator of a stationary source subject to this rule that contains a combustion emission unit shall keep and maintain the following records:

1. Information on equipment type, make and model, maximum design process rate or maximum power input/output, minimum operating temperature (for thermal oxidizers) and capacity and all source test information; and

2. A monthly log of fuel type, fuel usage, fuel heating value (for nonfossil fuels; in terms of Btu/lb or Btu/gal), and percent sulfur for fuel oil and coal.

(4) General emission unit. The owner or operator of a stationary source subject to this rule that contains an emission unit not included in subparagraph (1), (2), or (3) above shall keep and maintain the following records:

1. Information on the process and equipment including the following: equipment type, description, make and model; and maximum design process rate or throughput;

2. A monthly log of operating hours and each raw material used and its amount; and

3. Purchase orders, invoices, or other documents to support information in the monthly log.

(5) Emission control equipment. The owner or operator of a stationary source subject to this rule that contains emission control equipment shall keep and maintain the following records:

1. Information on equipment type and description, make and model, and emission units served by the control equipment;

2. Information on equipment design including, where applicable: pollutant(s) controlled; control effectiveness; and maximum design or rated capacity; other design data as appropriate including any available source test information and manufacturer's design/repair/maintenance manual; and

3. A monthly log of hours of operation including notation of any control equipment breakdowns, upsets, repairs, maintenance and any other deviations from design parameters.

**22.300(8) Registration and reporting requirements.**

*a.* Duty to apply. Any person who owns or operates a source otherwise required to obtain a Title V operating permit and which would be eligible for an operating permit by rule for small sources must either register for an operating permit by rule for small sources or apply for a Title V operating permit. Any source determined not to be eligible for an operating permit by rule for small sources, and operating without a valid Title V operating permit, shall be subject to enforcement action for operation without a Title V operating permit, except as provided for in the application shield provisions contained in rule 567—22.104(455B). For each source registering for an operating permit by rule for small sources, the owner or operator or designated representative, where applicable, shall present or mail to the Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, one original and one copy of a timely and complete registration form in accordance with this rule.

(1) Timely registration. Each source registering for an operating permit by rule for small sources shall submit a registration form:

1. By August 1, 1996, if the source became subject to rule 567—22.101(455B) on or before August 1, 1995, unless otherwise required to obtain a Title V permit under rule 567—22.101(455B).

2. Within 12 months of becoming subject to rule 567—22.101(455B) (the requirement to obtain a Title V operating permit) for a new source or a source which would otherwise become subject to the Title V permit requirement after August 1, 1995.

(2) Complete registration form. To be deemed complete the registration form must provide all information required pursuant to 22.300(8) "b."

(3) Duty to supplement or correct registration. Any registrant who fails to submit any relevant facts or who has submitted incorrect information in an operating permit by rule for small sources registration shall, upon becoming aware of such failure or incorrect submittal, promptly submit such supplementary facts or corrected information. In addition, the registrant shall provide additional information as necessary to address any requirements that become applicable to the source after the date it filed a complete registration.

(4) Certification of truth, accuracy, and completeness. Any registration form, report, or supplemental information submitted pursuant to these rules shall contain certification by a responsible official of truth, accuracy, and completeness. This certification and any other certification required under these rules shall state that, based on information and belief formed after reasonable inquiry, the statements and information in the document are true, accurate, and complete.

*b.* At the time of registration for an operating permit by rule for small sources each owner or operator of a stationary source shall submit to the department a standard registration form and required attachments. To register for an operating permit by rule for small sources, applicants shall complete the registration form and supply all information required by the filing instructions. The information submitted must be sufficient to evaluate the source, its registration, predicted actual emissions from the source; and to determine whether the source is subject to the exceptions listed in subrule 22.300(3). The standard registration form and attachments shall require that the following information be provided:

(1) Identifying information, including company name and address (or plant or source name if different from the company name), owner's name and responsible official, and telephone number and names of plant site manager or contact;

(2) A description of source processes and products;

(3) The following emissions-related information shall be submitted to the department on the standard registration form:

1. The total actual emissions of each regulated air pollutant. Actual emissions shall be reported for one contiguous 12-month period within the 18 months preceding submission of the registration to the department;

2. Identification and description of each emission unit with the potential to emit a regulated air pollutant;

3. Identification and description of air pollution control equipment;

4. Limitations on source operations affecting emissions or any work practice standards, where applicable, for all regulated pollutants;

5. Fugitive emissions sources shall be included in the registration form in the same manner as stack emissions if the source is one of the source categories defined as a stationary source category in rule 567—22.100(455B).

(4) Requirements for certification. Facilities which claim to meet the requirements set forth in this rule to qualify for an operating permit by rule for small sources must submit to the department, with a complete registration form, a written statement as follows:

"I certify that all equipment at the facility with a potential to emit any regulated pollutant is included in the registration form, and submitted to the department as required in 22.300(8) "b." I understand that the facility will be deemed to have been granted an operating permit by rule for small sources under the terms of rule 567—22.300(455B) only if all applicable requirements of rule 567—22.300(455B) are met and if the registration is not denied by the director under rule 567—22.300(11). This certification is based on information and belief formed after reasonable inquiry; the statements and information in the document are true, accurate, and complete." The certification must be signed by one of the following individuals.

For corporations, a principal executive officer of at least the level of vice president, or a responsible official as defined at rule 567—22.100(455B).

For partnerships, a general partner.

For sole proprietorships, the proprietor.

For municipal, state, county, or other public facilities, the principal executive officer or the ranking elected official.

**22.300(9)** *Construction permits issued after registration for an operating permit by rule for small sources.* This rule shall not relieve any stationary source from complying with requirements pertaining to any otherwise applicable construction permit, or to replace a condition or term of any construction permit, or any provision of a construction permitting program. This does not preclude issuance of any construction permit with conditions or terms necessary to ensure compliance with this rule.

*a.* If the issuance of a construction permit acts to make the source no longer eligible for an operating permit by rule for small sources, the source shall, within 12 months of issuance of the construction permit, submit an application for a Title V operating permit.

*b.* If the issuance of a construction permit does not prevent the source from continuing to be eligible to operate under an operating permit by rule for small sources, the source shall, within 30 days of issuance of a construction permit, provide to the department the information as listed in 22.300(8) "b" for the new or modified source.

**22.300(10)** *Violations.*

*a.* Failure to comply with any of the applicable provisions of this rule shall constitute a violation of this rule.

*b.* A stationary source subject to this rule shall be subject to applicable federal requirements for a major source, including rules 567—22.101(455B) to 567—22.116(455B) when the conditions specified in either subparagraph (1) or (2) below, occur:

(1) Commencing on the first day following every 12-month rolling period in which the stationary source exceeds a limit specified in subrule 22.300(6), or

(2) Commencing on the first day following every 12-month rolling period in which the owner or operator cannot demonstrate that the stationary source is in compliance with the limits in subrule 22.300(6).

**22.300(11) Suspension, termination, and revocation of an operating permit by rule for small sources.**

a. Registrations may be terminated, modified, revoked, or reissued for cause. The following examples shall be considered cause for the suspension, modification, revocation, or reissuance of an operating permit by rule for small sources:

(1) The director has reasonable cause to believe that the operating permit by rule for small sources was obtained by fraud or misrepresentation.

(2) The person registering for the operating permit by rule for small sources failed to disclose a material fact required by the registration form or the rules applicable to the operating permit by rule for small sources, of which the applicant had or should have had knowledge at the time the registration form was submitted.

(3) The terms and conditions of the operating permit by rule for small sources have been or are being violated.

(4) The owner or operator of the source has failed to pay an administrative, civil or criminal penalty for violations of the operating permit by rule for small sources.

b. If the director suspends, terminates or revokes an operating permit by rule for small sources under this rule, the notice of such action shall be served on the applicant by certified mail, return receipt requested. The notice shall include a statement detailing the grounds for the action sought, and the proceeding shall in all other respects comply with the requirements of rule 561—7.16(17A,455A).

**22.300(12) Change of ownership.** The new owner shall notify the department in writing no later than 30 days after the change of ownership of equipment covered by an operating permit by rule for small sources. The notification to the department shall be mailed to Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, and shall include the following information:

a. The date of ownership change; and

b. The name, address and telephone number of the responsible official, the contact person and the owner of the equipment both before and after the change of ownership.

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These rules are intended to implement Iowa Code sections 455B.133 and 455B.134.

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<sup>0</sup> Two or more ARCs

<sup>1</sup> Effective date of 22.1(455B) [DEQ, 3.1] delayed by the Administrative Rules Review Committee 70 days from June 21, 1978. The Administrative Rules Review Committee at the August 15, 1978 meeting delayed 22.1 [DEQ, 3.1] under provisions of 67GA, SF244, §19. (See HJR 6, 1/22/79).

<sup>2</sup> Effective date of 22.100(455B), definition of “12-month rolling period”; 22.200(455B); 22.201(1)“a,” “b,”; 22.201(2)“a”; 22.206(2)“c,” delayed 70 days by the Administrative Rules Review Committee at its meeting held October 10, 1995; delay lifted by this Committee December 13, 1995, effective December 14, 1995.

<sup>3</sup> Effective date of 22.300 delayed 70 days by the Administrative Rules Review Committee at its meeting held June 11, 1996; delay lifted by this Committee at its meeting held June 12, 1996, effective June 12, 1996.

<sup>4</sup> Effective date of 22.1(2), unnumbered introductory paragraphs and paragraphs “g” and “i,” delayed 70 days by the Administrative Rules Review Committee at its meeting held March 9, 2001.



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 June 28, 2011, 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. An earlier date for adoption by reference may be included with the subpart designation 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 as amended through October 17, 2000)

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*h. Secondary lead smelters.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*n. Primary zinc smelters.* Rescinded IAB 3/18/15, effective 4/22/15.

*o. Primary lead smelter.* Rescinded IAB 3/18/15, effective 4/22/15.

*p. Primary aluminum reduction plants.* Rescinded IAB 3/18/15, effective 4/22/15.

*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: SO<sub>2</sub> 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). Any person subject to notification requirements under this rule shall submit fees as required in 567—Chapter 30.

*b. Beryllium.* Rescinded IAB 3/18/15, effective 4/22/15.

*c. Beryllium rocket motor firing.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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 December 21, 2012, 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 (except for paragraph 23.1(4) “cz,” which specifies a later date for adoption by reference). 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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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 as amended through December 20, 2006)

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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 and to new and existing area sources with stationary reciprocating internal combustion engines (RICE). 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, as amended through January 30, 2013)

*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 PTTTT)

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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.* Rescinded IAB 3/18/15, effective 4/22/15.

*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 WTTTT)

*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. Emission 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)

*ey.* Reserved.

*ez. Emission standards for hazardous air pollutants for area sources: aluminum, copper, and other nonferrous foundries.* This standard applies to aluminum, copper, and other nonferrous foundries at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart ZZZZZZ)

*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 CCCCCC)

*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) (See Rescission note at end of chapter); ARC 0329C, IAB 9/19/12, effective 10/24/12; ARC 1014C, IAB 9/18/13, effective 10/23/13; ARC 1561C, IAB 8/6/14, effective 9/10/14; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2352C, IAB 1/6/16, effective 12/16/15]

### **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

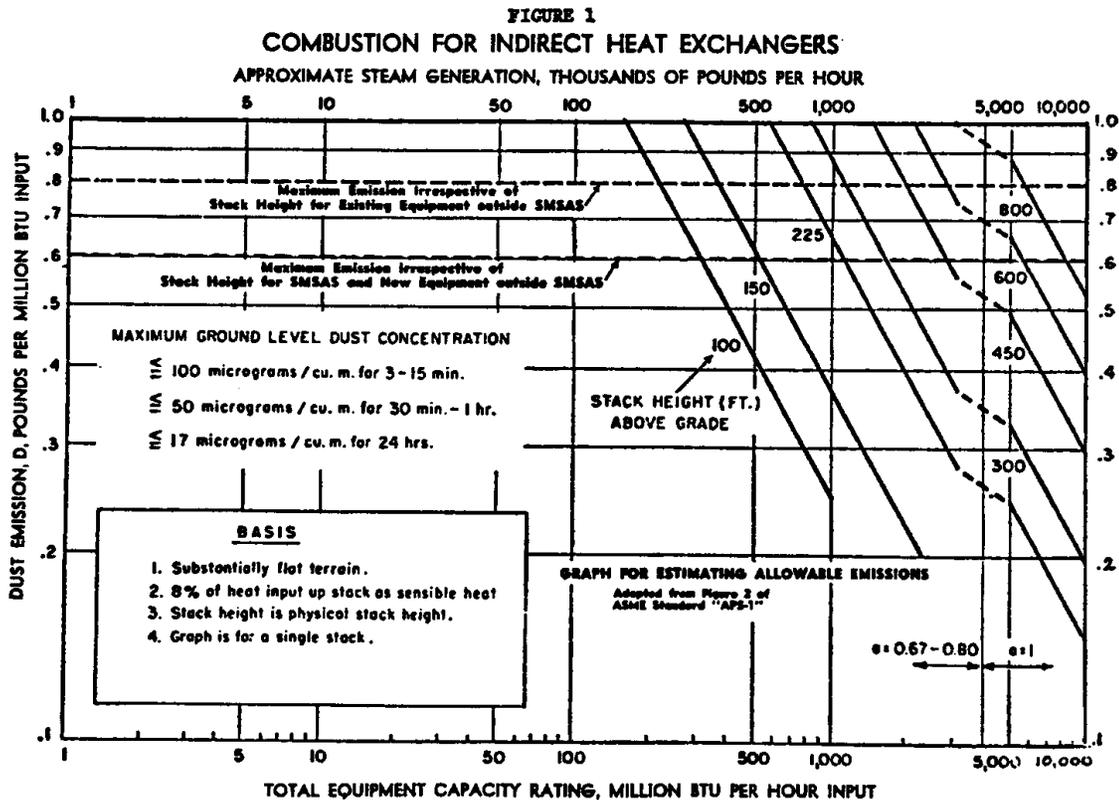
b. *Combustion for indirect heating.* Emissions of particulate matter from the combustion of fuel for indirect heating or for power generation shall be limited by the ASME Standard APS-1, Second Edition, November, 1968, "Recommended Guide for the Control of Dust Emission—Combustion for Indirect Heat 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.



(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
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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<sup>0</sup> Two or more ARCs

<sup>1</sup> Objection, see filed rule [DEQ, 4.2(4)] published IAC Supp. 1/22/77, 3/9/77.

<sup>2</sup> Effective date of 23.2(4) delayed 70 days by the Administrative Rules Review Committee on 9/14/83.

<sup>3</sup> 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.

<sup>4</sup> Amendment to 23.1(4), introductory paragraph, (ARC 9154B, Item 4) rescinded by Executive Order Number 72 on 4/4/11. Amendment removed and prior language restored IAC Supplement 4/20/11.

CHAPTER 30  
FEES

**567—30.1(455B) Purpose.** This chapter sets forth requirements to pay fees for specified activities. Rule 567—30.1(455B) adds definitions for this chapter, a duty to correct errors, and an exemption to fee requirements for administrative amendments. Rule 567—30.2(455B) sets forth the requirements for applicants to submit fees for specified activities associated with new source review in 567—Chapter 22, 567—Chapter 31 and 567—Chapter 33. Rule 567—30.3(455B) contains requirements for the submission of demolition and renovation notification fees for the asbestos emission standard for hazardous air pollutants listed in 567—paragraph 23.1(3)“a.” Rule 567—30.4(455B) sets forth the requirements for applicants to submit fees for specified activities associated with the Title V program found in 567—Chapter 22. Rule 567—30.5(455B) sets forth the requirement to convene fee advisory groups. Rule 567—30.6(455B) details the process by which fee levels shall be established, lists the types of fees and the dollar caps on the fee types that the commission may set, and establishes the mechanism for notification of the fee schedule. Rule 567—30.7(455B) details how fee revenues may be expended and specifies the calculated estimate of maximum fee revenues.

The department shall not initiate review and processing of an application submittal from a minor source until all required fees have been paid to the department. Fees are nonrefundable, except as provided in subrule 30.1(4).

**30.1(1) Definitions.** For purposes of this chapter, the following definitions shall apply:

“*Application submittal*” means one or more applications required under rule 567—22.1(455B) and submitted at the same time or required to be submitted under rule 567—22.4(455B), rule 567—22.5(455B), 567—Chapter 31 or 567—Chapter 33.

“*Major source*” means a “major source” as defined in rule 567—22.100(455B).

“*Minor source*” means any stationary source not included in the definition of “major source” as defined in rule 567—22.100(455B).

“*Regulated air pollutant*” means “regulated air pollutant or contaminant (for fee calculation)” as defined in rule 567—22.100(455B).

**30.1(2) Duty to correct errors.** If an owner or operator, or the department, finds an error in a fee assessed or collected under this chapter, the owner or operator shall submit to the department revised forms making the necessary corrections to the fee and shall submit the correct fee. Corrected forms shall be submitted as soon as possible after the error is discovered or upon notification by the department. If the error correction results in a determination by the department that a fee was overpaid or that a duplicate fee was submitted, the department will return the overpaid balance of the fee to the applicant.

**30.1(3) Exemption to fee requirements for administrative amendments.** A fee shall not be required for any of the following:

- a. Corrections of typographical errors;
- b. Corrections of word processing errors;
- c. Changes in the name, address, or telephone number of any person identified in a permit, or similar minor administrative changes at the source;
- d. Changes in ownership or operational control of a source where the department determines that no other change in the permit is necessary, provided that a written agreement that contains a specific date for transfer of permit responsibility, coverage, and liability between the current permittee and the new permittee has been submitted to the department.

**30.1(4) Refund of application fee minus administrative cost for permit applications at minor sources.** The department may refund the application fee minus administrative costs if the owner or operator requests to withdraw the application prior to commencement of the technical review of the application.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.2(455B) Fees associated with new source review applications.** Beginning on January 15, 2016, each owner or operator required to provide an application submittal, including air quality

modeling as applicable; registration; permit by rule; and template under 567—subrule 22.1(1), rule 567—22.4(455B), rule 567—22.5(455B), rule 567—22.8(455B), rule 567—22.10(455B), 567—Chapter 31 or 567—Chapter 33, shall pay fees as specified in the fee schedule approved by the commission and posted on the department’s Web site. Fees shall be submitted with forms supplied by the department.

**30.2(1) *Payment of regulatory applicability determination fee.*** Beginning on January 15, 2016, each owner or operator requesting a regulatory applicability determination, as specified in 567—paragraph 22.1(3) “a,” shall pay fees as specified in the fee schedule approved by the commission and posted on the department’s Web site. Fees shall be submitted with forms provided by the department.

**30.2(2) Reserved.**

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.3(455B) Fees associated with asbestos demolition or renovation notification.**

**30.3(1) *Payment of fees established.*** Beginning on January 15, 2016, the owner or operator of a site subject to the national emission standard for hazardous air pollutants (NESHAP) for asbestos notifications, adopted by reference in 567—paragraph 23.1(3) “a,” shall submit a fee with each required original or each annual notification for each demolition or renovation, including abatement. Fees shall be paid as specified in the fee schedule approved by the commission and posted on the department’s Web site. Fees shall be submitted with the notification forms provided by the department.

**30.3(2) *Fee not required.*** A fee shall not be required for the following:

- a. Notifications when the total amount of asbestos to be removed or disturbed is less than 260 linear feet, less than 160 square feet, and less than 35 cubic feet of facility components and is below the reporting thresholds as defined in 40 CFR 61.145 as amended on January 16, 1991;
- b. Notifications of training fires as required in 567—paragraph 23.2(3) “g”;
- c. Controlled burning of demolished buildings as required in 567—paragraph 23.2(3) “j”;
- d. Revised, canceled, and courtesy notifications. A revision to a previously submitted courtesy notification due to applicability of the notification requirements in 567—paragraph 23.1(3) “a” is considered an original notification and is subject to the fee requirements of subrule 30.3(1).

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.4(455B) Fees associated with Title V operating permits.**

**30.4(1) *Payment of Title V application fee.*** Beginning on January 15, 2016, each owner or operator required to apply for a Title V permit, or a renewal of a Title V permit, shall pay fees as specified in the fee schedule approved by the commission and posted on the department’s Web site. Fees shall be submitted with forms supplied by the department.

**30.4(2) *Payment of Title V annual emissions fee.***

a. *Fee required.* Any person required to obtain a Title V permit shall pay an annual fee based on the first 4,000 tons of each regulated air pollutant, beginning on November 15, 1994. Beginning on July 1, 1996, Title V operating permit fees shall be paid on or before July 1 of each year. The Title V emissions fee shall be based on actual emissions required to be included in the Title V operating permit application and the annual emissions statement for the previous calendar year. The commission shall not set the fee higher than \$70 per ton without adopting the change pursuant to formal rule making.

b. *Fee and documentation due dates.* The fee shall be submitted annually by July 1. The fee shall be submitted with a copy of the following forms:

- (1) Form 1.0, “Facility Identification”;
- (2) Form 5.0, “Title V Annual Emissions Summary/Fee”; and
- (3) Part 3, “Application Certification.”

c. *Phase I acid rain sources.* No fee shall be required to be paid for emissions which occurred during the years 1993 through 1999, inclusive, with respect to any Phase I acid rain affected unit under 42 U.S.C. 7651c.

d. *Operation in Iowa.* The fee for a portable emissions unit or stationary source which operates both in Iowa and out of state shall be calculated only for emissions from the source while it is operating in Iowa.

*e. Title V exempted stationary sources.* No fee shall be required for emissions until the year in which sources exempted under 567—subrules 22.102(1) and 22.102(2) are required to apply for a Title V permit. Fees shall be paid for the emission year preceding the year in which the application is due and thereafter.

*f. Insignificant activities.* No fee shall be required for insignificant activities as defined in rule 567—22.103(455B).

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.5(455B) Fee advisory groups.** Prior to each March commission meeting, the director shall convene fee advisory groups for the purposes of reviewing a draft budget and providing recommendations to the department regarding establishing or adjusting fees. Any stakeholder may attend meetings of the advisory groups. The meetings will be open to the public. The date of each meeting shall be posted on the department's Web site 14 days prior to the meeting date.

**30.5(1) New source review for major sources fee advisory group.** The director shall convene annually a fee advisory group to review the draft budget and major source fees required by rule 567—30.2(455B) and listed in rule 567—30.6(455B). Participants in the advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the major source permit program.

**30.5(2) New source review for minor sources fee advisory group.** The director shall convene annually a fee advisory group which shall not include major sources as defined in subrule 30.1(1). The fee advisory group will review the draft budget and minor source application fees required in rule 567—30.2(455B) and listed in rule 567—30.6(455B). Participants in the fee advisory group shall include, but may not be limited to, any minor sources and their representatives. The advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the minor source permit program.

**30.5(3) Asbestos fee advisory group.** The director shall convene annually an asbestos NESHAP fee advisory group to review the draft budget and asbestos notification fee required by rule 567—30.3(455B) and listed in rule 567—30.6(455B). Participants in the advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the asbestos NESHAP program.

**30.5(4) Title V fee advisory group.** The director shall convene annually a fee advisory group to review the draft budget and Title V emissions and application fees required by rule 567—30.4(455B) and listed in rule 567—30.6(455B). Participants in the advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the Title V operating permit program.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.6(455B) Process to establish or adjust fees and notification of fee rates.**

**30.6(1) Setting the fees.** Beginning on January 15, 2016, fees shall be paid as specified in the fee schedule approved by the commission and posted on the department's Web site. Following the setting of the fee schedule effective January 15, 2016, the department shall submit the proposed budget and fees for major and minor source construction permit programs, the Title V operating permit program, and the asbestos NESHAP program for the following fiscal year to the commission no later than the March commission meeting of each year, at which time the proposal will be available for public comment until such time as the commission acts on the proposal or until the May commission meeting, whichever occurs first. The department's calculated estimate for each fee shall not produce total revenues in excess of limits specified in Iowa Code sections 455B.133B and 455B.133C during any fiscal year. If an established fee amount must be adjusted, the commission shall set the fees no later than the May commission meeting of each year.

Fees established prior to January 15, 2016, shall become effective on January 15, 2016. In subsequent years, adjusted or established fees shall become effective on July 1. A fee not adjusted by the commission shall remain in effect as previously established until the fee is adjusted by the commission.

**30.6(2) *Fee types and dollar caps on fee types.*** The commission may set fees for the fee types and activities specified in this subrule and shall not set a fee in the fee schedule higher than the levels specified in this subrule without adopting the change pursuant to formal rule making:

- a. New source review applications from major sources, which may include:
  - (1) Review of each application for a construction permit: \$115 per hour;
  - (2) Review of each application for a prevention of significant deterioration permit: \$115 per hour;
  - (3) Review of each plantwide applicability limit request, renewal, or reopening: \$115 per hour;
  - (4) Review of each regulatory applicability determination: \$115 per hour; and
  - (5) Air quality modeling review: \$90 per hour, which may include:
    - 1. Reviewing air quality modeling for construction permit application submittal; prevention of significant deterioration application submittal; and nonattainment new source review project application submittal; and
    - 2. Conducting air quality modeling for construction permit application submittal.
- b. New source review applications from minor sources, which may include:
  - (1) Each application for a construction permit: \$385;
  - (2) Each application for a registration permit: \$100;
  - (3) Each application for a permit by rule: \$100; and
  - (4) Each application for a permit template: \$100.
- c. Asbestos notifications: \$100.
- d. Review of each initial or renewal Title V operating permit application: \$100 per hour.
- e. Title V annual emissions: \$70 per ton.

**30.6(3) *Notification of fee schedule.*** Following the initial setting of any fee by the commission, the department shall make available to the public a fee schedule at least 30 days prior to its effective date. If any established fee amount is adjusted, the department shall make available to the public a revised fee schedule at least 30 days prior to its effective date. The fee schedule shall be posted on the department's Web site.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.7(455B) Fee revenue.** Each fee program is established to provide revenue for and is limited in use to specific activities.

**30.7(1) *New source review application fees from major sources.*** In accordance with Iowa Code section 455B.133C(5), new source review fee revenues may be used to fund the direct and indirect costs related to reviewing and acting on applications for new source review permits, including permit revisions submitted by major sources as defined under new source review programs pursuant to the federal Act, and as provided under 567—Chapter 22, 567—Chapter 31, and 567—Chapter 33, as follows:

- a. Reviewing and acting on any application for a new source review permit, including the determination of all applicable requirements and dispersion modeling as part of the processing of a permit or permit revision or an applicability determination;
- b. General administrative costs of administering new source review programs, including supporting and tracking of any application for a new source review permit and related data entry; and
- c. Developing and implementing an expedited new source review permit application process, and additional fees associated with this process.

The calculated estimate of total revenues from new source review application fees from major sources shall not exceed \$1,500,000 during any state fiscal year.

**30.7(2) *New source review application fees from minor sources.*** In accordance with Iowa Code section 455B.133C(6), minor new source review fee revenues may be used to fund the direct and indirect costs for reviewing and acting on applications submitted by minor air contaminant sources for construction permits and providing for registrations, permits by rule, or template permits in lieu of obtaining construction permits, under minor source new source review programs pursuant to the federal Clean Air Act Amendments of 1990, including as provided under 567—Chapter 22. The calculated estimate of total revenues from new source review application fees from minor sources shall not exceed \$250,000 during any state fiscal year.

**30.7(3) Title V emissions.** In accordance with Iowa Code section 455B.133B(5), Title V emissions fee revenues may be used to fund the direct and indirect costs related to:

*a.* General administrative costs of administering the operating permit program, including the supporting and tracking of operating permit applications, compliance certification, and related data entry.

*b.* Costs of implementing and enforcing the terms of an operating permit, not including any court costs or other costs associated with an enforcement action, including adequate resources to determine which sources are subject to the program.

*c.* Costs of emissions and ambient site-specific monitors.

*d.* Costs of Title V source-specific modeling, analyses or demonstrations.

*e.* Costs of preparing inventories and tracking emissions.

*f.* Costs of providing direct support to sources under the small business stationary source technical and environmental compliance assistance program as provided in Iowa Code section 455B.133A.

*g.* Costs associated with implementing and administering regulatory activities, including programs, as provided for in division II of Iowa Code chapter 455B, other than costs covered by any of the following: operating permit application fees, new source review application fees, or notification fees, pursuant to Iowa Code section 455B.133B(5) “d”(2).

The calculated estimate of total revenues from emissions fees shall not exceed \$8,250,000 during any state fiscal year.

**30.7(4) Title V applications.** In accordance with Iowa Code section 455B.133B(6), Title V application fee revenues may be used to fund the direct and indirect costs related to reviewing and acting on applications for operating permits submitted by major sources as defined in rule 567—22.100(455B) and sources subject to rule 567—22.101(455B), as follows:

*a.* Costs of reviewing and acting on any application for an operating permit or operating permit revision.

*b.* General administrative costs of administering the operating permit program, including the supporting and tracking of operating permit applications and related data entry.

The calculated estimate of total revenues from Title V application fees shall not exceed \$1,250,000 during any state fiscal year.

**30.7(5) Asbestos notification.** Pursuant to Iowa Code section 455B.133C(7), asbestos notification fee revenues may be used to fund the direct and indirect costs related to implementing and administering the asbestos national emission standard for hazardous air pollutants program pursuant to 567—Chapter 23. The calculated estimate of total revenues from asbestos notification fees shall not exceed \$450,000 during any state fiscal year.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

These rules are intended to implement Iowa Code sections 455B.133, 455B.133B and 455B.133C.  
[Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective 12/16/15]



CHAPTER 31  
NONATTAINMENT AREAS

**567—31.1(455B) Permit requirements relating to nonattainment areas.** This chapter implements the nonattainment major new source review (NSR) program contained in Part D of Title I of the federal Clean Air Act and as promulgated under 40 CFR 51.165 as amended through March 30, 2011, and 40 CFR 51, Appendix S, as amended through July 1, 2011.

The nonattainment major NSR program is a preconstruction review and permitting program applicable to new or modified major stationary sources of air pollutants regulated under Part D of Title I of the federal Clean Air Act as amended on November 15, 1990. The nonattainment major NSR program applies only in areas that do not meet the national ambient air quality standards (NAAQS).

Section 107(d) of the federal Clean Air Act, 42 U.S.C. §7457(d), requires each state to submit to the Administrator of the federal Environmental Protection Agency a list of areas that exceed the NAAQS, that are lower than those standards, or that cannot be classified on the basis of current data.

Requirements for nonattainment areas designated on or after May 18, 1998, are in rules 567—31.3(455B) through 567—31.10(455B). Requirements for nonattainment areas designated before May 18, 1998, are in rule 567—31.20(455B). A list of Iowa's nonattainment area designations is found at 40 CFR 81.316 as amended through August 5, 2013. An owner or operator required to apply for a construction permit under this chapter or requesting a plantwide applicability limit shall submit fees as required in 567—Chapter 30.

[ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—31.2(455B) Conformity of general federal actions to the Iowa state implementation plan or federal implementation plan.** The federal regulations relating to determining conformity of general federal actions to state or federal implementation plans, 40 CFR 93.150 and 93.152 through 93.165, as amended through April 5, 2010, are adopted by reference.

[ARC 1227C, IAB 12/11/13, effective 1/15/14]

NONATTAINMENT AREAS DESIGNATED ON OR AFTER MAY 18, 1998

**567—31.3(455B) Nonattainment new source review requirements for areas designated nonattainment on or after May 18, 1998.**

**31.3(1) Definitions.** For the purpose of nonattainment new source review, the following definitions shall apply:

“Act” means the Clean Air Act, 42 U.S.C. Sections 7401, et seq., as amended through November 15, 1990.

“Actual emissions” means:

1. The actual rate of emissions of a regulated NSR pollutant from an emissions unit, as determined in accordance with paragraphs “2” through “4,” except that this definition shall not apply for calculating whether a significant emissions increase has occurred, or for establishing a PAL under rule 567—31.9(455B). Instead, the definitions of projected actual emission and baseline actual emissions shall apply for those purposes.

2. In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a consecutive 24-month period which precedes the particular date and which is representative of normal source operation. The department shall allow the use of a different time period upon a determination that it is more representative of normal source operation. Actual emissions shall be calculated using the unit's actual operating hours, production rates, and types of materials processed, stored, or combusted during the selected time period.

3. The department may presume that source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

4. For any emissions unit that has not begun normal operations on the particular date, actual emissions shall equal the potential to emit of the unit on that date.

*“Administrator”* means the administrator for the U. S. Environmental Protection Agency (EPA) or designee.

*“Allowable emissions”* means the emissions rate of a stationary source calculated using the maximum rated capacity of the source (unless the source is subject to federally enforceable limits which restrict the operating rate, or hours of operation, or both) and the most stringent of the following:

1. The applicable standards as set forth in 567—subrules 23.1(2) through 23.1(5) (new source performance standards, emissions standards for hazardous air pollutants, and federal emissions guidelines) or an applicable federal standard not adopted by the state, as set forth in 40 CFR Parts 60, 61 and 63;

2. The state implementation plan (SIP) emissions limitation, including those with a future compliance date; or

3. The emissions rate specified as an enforceable permit condition, including those with a future compliance date.

*“Baseline actual emissions,”* for the purposes of this rule, means the rate of emissions, in tons per year, of a regulated NSR pollutant, as determined in accordance with paragraphs “1” through “4.”

1. For any existing electric utility steam generating unit, baseline actual emissions means the average rate, in tons per year, at which the unit actually emitted the pollutant during any consecutive 24-month period selected by the owner or operator within the five-year period immediately preceding when the owner or operator begins actual construction of the project. The department shall allow the use of a different time period upon a determination that it is more representative of normal source operation.

- (a) The average rate shall include fugitive emissions to the extent quantifiable, and emissions associated with startups, shutdowns, and malfunctions.

- (b) The average rate shall be adjusted downward to exclude any non-compliant emissions that occurred while the source was operating above an emissions limitation that was legally enforceable during the consecutive 24-month period.

- (c) For a regulated NSR pollutant, when a project involves multiple emissions units, only one consecutive 24-month period must be used to determine the baseline actual emissions for the emissions units being changed. A different consecutive 24-month period can be used for each regulated NSR pollutant.

- (d) The average rate shall not be based on any consecutive 24-month period for which there is inadequate information for determining annual emissions, in tons per year, and for adjusting this amount if required by paragraph “1”(b) of this definition.

2. For an existing emissions unit (other than an electric utility steam generating unit), baseline actual emissions means the average rate, in tons per year, at which the emissions unit actually emitted the pollutant during any consecutive 24-month period selected by the owner or operator within the ten-year period immediately preceding either the date the owner or operator begins actual construction of the project, or the date on which a complete permit application is received by the department for a permit required either under this rule or under a plan approved by the Administrator, whichever is earlier, except that the ten-year period shall not include any period earlier than November 15, 1990.

- (a) The average rate shall include fugitive emissions to the extent quantifiable, and emissions associated with startups, shutdowns, and malfunctions.

- (b) The average rate shall be adjusted downward to exclude any non-compliant emissions that occurred while the source was operating above an emission limitation that was legally enforceable during the consecutive 24-month period.

- (c) The average rate shall be adjusted downward to exclude any emissions that would have exceeded an emission limitation with which the major stationary source must currently comply, had such major stationary source been required to comply with such limitations during the consecutive 24-month period. However, if an emission limitation is part of a maximum achievable control technology standard that the Administrator proposed or promulgated under 40 CFR Part 63, the baseline actual emissions need only be adjusted if the state has taken credit for such emissions reductions in an attainment demonstration or maintenance plan consistent with the requirements of subparagraph 31.3(3) “b”(7).

(d) For a regulated NSR pollutant, when a project involves multiple emissions units, only one consecutive 24-month period must be used to determine the baseline actual emissions for the emissions units being changed. A different consecutive 24-month period can be used for each regulated NSR pollutant.

(e) The average rate shall not be based on any consecutive 24-month period for which there is inadequate information for determining annual emissions, in tons per year, and for adjusting this amount if required by paragraphs “2”(b) and “2”(c) of this definition.

3. For a new emissions unit, the baseline actual emissions for purposes of determining the emissions increase that will result from the initial construction and operation of such unit shall equal zero; and thereafter, for all other purposes, shall equal the unit’s potential to emit.

4. For a PAL for a major stationary source, the baseline actual emissions shall be calculated for existing electric utility steam generating units in accordance with the procedures contained in paragraph “1,” for other existing emissions units in accordance with the procedures contained in paragraph “2,” and for a new emissions unit in accordance with the procedures contained in paragraph “3.”

“*Begin actual construction*” means, in general, initiation of physical on-site construction activities on an emissions unit which are of a permanent nature. Such activities include, but are not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures. With respect to a change in method of operating this term refers to those on-site activities other than preparatory activities which mark the initiation of the change.

“*Best available control technology*” or “*BACT*” means an emissions limitation, including a visible emissions standard, based on the maximum degree of reduction for each regulated NSR pollutant which would be emitted from any proposed major stationary source or major modification which the department, on a case-by-case basis, taking into account energy, environmental, and economic impacts and other costs, determines is achievable for such source or modification through application of production processes or available methods, systems, and techniques, including fuel cleaning or treatment or innovative fuel combustion techniques for control of such pollutant. In no event shall application of best available control technology result in emissions of any pollutant which would exceed the emissions allowed by any applicable standard under 567—subrules 23.1(2) through 23.1(5) (standards for new stationary sources, federal standards for hazardous air pollutants, and federal emissions guidelines), or federal regulations as set forth in 40 CFR Parts 60, 61 and 63 but not yet adopted by the state. If the department determines that technological or economic limitations on the application of measurement methodology to a particular emissions unit would make the imposition of an emissions standard infeasible, a design, equipment, work practice, operational standard, or combination thereof, may be prescribed instead to satisfy the requirement for the application of BACT. Such standard shall, to the degree possible, set forth the emissions reduction achievable by implementation of such design, equipment, work practice or operation, and shall provide for compliance by means which achieve equivalent results.

“*Building, structure, facility, or installation*” means all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same major group (i.e., which have the same two-digit code) as described in the Standard Industrial Classification Manual, 1972, as amended by the 1977 Supplement (U.S. Government Printing Office stock numbers 4101-0065 and 003-005-00176-0, respectively).

“*CFR*” means the Code of Federal Regulations, with standard references in this chapter by title and part, so that “40 CFR 51” or “40 CFR Part 51” means “Title 40 Code of Federal Regulations, Part 51.”

“*Clean coal technology*” means any technology, including technologies applied at the precombustion, combustion, or post combustion stage, at a new or existing facility which will achieve significant reductions in air emissions of sulfur dioxide or oxides of nitrogen associated with the utilization of coal in the generation of electricity, or process steam which was not in widespread use as of November 15, 1990.

“*Clean coal technology demonstration project*” means a project using funds appropriated under the heading “Department of Energy—Clean Coal Technology,” up to a total amount of \$2,500,000,000 for commercial demonstration of clean coal technology, or similar projects funded through appropriations for the EPA. The federal contribution for a qualifying project shall be at least 20 percent of the total cost of the demonstration project.

“*Commence*,” as applied to construction of a major stationary source or major modification, means that the owner or operator has all necessary preconstruction approvals or permits and either has:

1. Begun, or caused to begin, a continuous program of actual on-site construction of the source, to be completed within a reasonable time; or
2. Entered into binding agreements or contractual obligations, which cannot be canceled or modified without substantial loss to the owner or operator, to undertake a program of actual construction of the source to be completed within a reasonable time.

“*Construction*” means any physical change or change in the method of operation, including fabrication, erection, installation, demolition, or modification of an emissions unit, that would result in a change in emissions.

“*Continuous emissions monitoring system*” or “*CEMS*” means all of the equipment that may be required to meet the data acquisition and availability requirements of this rule, to sample, to condition (if applicable), to analyze, and to provide a record of emissions on a continuous basis.

“*Continuous emissions rate monitoring system*” or “*CERMS*” means the total equipment required for the determination and recording of the pollutant mass emissions rate (in terms of mass per unit of time).

“*Continuous parameter monitoring system*” or “*CPMS*” means all of the equipment necessary to meet the data acquisition and availability requirements of this rule, to monitor process and control device operational parameters (for example, control device secondary voltages and electric currents) and other information (for example, gas flow rate, O<sub>2</sub> or CO<sub>2</sub> concentrations), and to record average operational parameter value(s) on a continuous basis.

“*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 electrical output to any utility power distribution system for sale. 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 also considered in determining the electrical energy output capacity of the affected facility.

“*Emissions unit*” means any part of a stationary source that emits or would have the potential to emit any regulated NSR pollutant and includes an electric steam generating unit. For purposes of this rule, there are two types of emissions units as described in paragraphs “1” and “2.”

1. A new emissions unit is any emissions unit which is (or will be) newly constructed and which has existed for less than two years from the date such emissions unit first operated.
2. An existing emissions unit is any emissions unit that does not meet the requirements in paragraph “1” of this definition. A replacement unit is an existing emissions unit.

“*Federal land manager*” means, with respect to any lands in the United States, the secretary of the department with authority over such lands.

“*Federally enforceable*” means all limitations and conditions which are enforceable by the Administrator and the department, including those federal requirements not yet adopted by the state, developed pursuant to 40 CFR Parts 60, 61, and 63; requirements within 567—subrules 23.1(2) through 23.1(5); requirements within the SIP; any permit requirements established pursuant to 40 CFR 52.21 or under regulations approved pursuant to 40 CFR Part 51, Subpart I, as amended through October 20, 2010, including operating permits issued under an EPA-approved program that is incorporated into the SIP and expressly requires adherence to any permit issued under such program.

“*Fugitive emissions*” means those emissions which could not reasonably pass through a stack, chimney, vent or other functionally equivalent opening.

“*Lowest achievable emission rate*” or “*LAER*” means, for any source, the more stringent rate of emissions based on the following:

1. The most stringent emissions limitation which is contained in the implementation plan of any state for such class or category of stationary source, unless the owner or operator of the proposed stationary source demonstrates that such limitations are not achievable; or

2. The most stringent emissions limitation which is achieved in practice by such class or category of stationary sources. This limitation, when applied to a modification, means the lowest achievable emissions rate for the new or modified emissions units within or stationary source. In no event shall the application of the term permit a proposed new or modified stationary source to emit any pollutant in excess of the amount allowable under an applicable new source standard of performance.

*“Major modification”* means any physical change in or change in the method of operation of a major stationary source that would result in a significant emissions increase of a regulated NSR pollutant and a significant net emissions increase of that pollutant from the major stationary source.

1. Any significant emissions increase from any emissions units or net emissions increase at a major stationary source that is significant for volatile organic compounds shall be considered significant for ozone.

2. A physical change or change in the method of operation shall not include:

(a) Routine maintenance, repair and replacement;

(b) Use of an alternative fuel or raw material by reason of an order under Sections 2(a) and (b) of the Energy Supply and Environmental Coordination Act of 1974 (or any superseding legislation) or by reason of a natural gas curtailment plan pursuant to the Federal Power Act;

(c) Use of an alternative fuel by reason of an order or rule Section 125 of the Act;

(d) Use of an alternative fuel at a steam generating unit to the extent that the fuel is generated from municipal solid waste;

(e) Use of an alternative fuel or raw material by a stationary source which the source was capable of accommodating before December 21, 1976, unless such change would be prohibited under any federally enforceable permit condition which was established after December 12, 1976, pursuant to 40 CFR 52.21 or under regulations approved pursuant to 40 CFR Subpart I or § 51.166; or the source is approved to use under any permit issued under regulations approved pursuant to this rule;

(f) An increase in the hours of operation or in the production rate, unless such change is prohibited under any federally enforceable permit condition which was established after December 21, 1976, pursuant to 40 CFR 52.21 or regulations approved pursuant to 40 CFR Part 51, Subpart I, or 40 CFR 51.166.

(g) Any change in ownership at a stationary source.

(h) Reserved.

(i) The installation, operation, cessation, or removal of a temporary clean coal technology demonstration project, provided that the project complies with the SIP, and other requirements necessary to attain and maintain the national ambient air quality standard during the project and after it is terminated.

3. This definition shall not apply with respect to a particular regulated NSR pollutant when the major stationary source is complying with the requirements under rule 567—31.9(455B) of this chapter for a PAL for that pollutant. Instead, the definition at 567—31.9(455B) shall apply.

4. For the purpose of applying the requirements of subrule 31.3(8) to modifications at major stationary sources of nitrogen oxides located in ozone nonattainment areas or in ozone transport regions, whether or not subject to Subpart 2, Part D, Title I of the Act, any significant net emissions increase of nitrogen oxides is considered significant for ozone.

5. Any physical change in, or change in the method of operation of, a major stationary source of volatile organic compounds that results in any increase in emissions of volatile organic compounds from any discrete operation, emissions unit, or other pollutant emitting activity at the source shall be considered a significant net emissions increase and a major modification for ozone, if the major stationary source is located in an extreme ozone nonattainment area that is subject to Subpart 2, Part D, Title I of the Act.

*“Major stationary source”* means:

1. Any stationary source of air pollutants that emits, or has the potential to emit, 100 tons per year or more of any regulated NSR pollutant, except that lower emissions thresholds shall apply in areas subject to Subpart 2, Subpart 3, or Subpart 4 of Part D, Title I of the Act, according to definitions in 31.3(1).

- (a) 50 tons per year of volatile organic compounds in any serious ozone nonattainment area.
- (b) 50 tons per year of volatile organic compounds in an area within an ozone transport region, except for any severe or extreme ozone nonattainment area.
- (c) 25 tons per year of volatile organic compounds in any severe ozone nonattainment area.
- (d) 10 tons per year of volatile organic compounds in any extreme ozone nonattainment area.
- (e) 50 tons per year of carbon monoxide in any serious nonattainment area for carbon monoxide, where stationary sources contribute significantly to carbon monoxide levels in the area (as determined under rules issued by the Administrator as amended through [effective date of these rules]).
- (f) 70 tons per year of PM<sub>10</sub> in any serious nonattainment area for PM<sub>10</sub>;

2. For the purposes of applying the requirements of subrule 31.3(8) to stationary sources of nitrogen oxides located in an ozone nonattainment area or in an ozone transport region, any stationary source which emits, or has the potential to emit, 100 tons per year or more of nitrogen oxides emissions, except that the following emission thresholds apply in areas subject to Subpart 2 of Part D, Title I of the Act:

- (a) 100 tons per year or more of nitrogen oxides in any ozone nonattainment area classified as marginal or moderate.
- (b) 100 tons per year or more of nitrogen oxides in any ozone nonattainment area classified as a transitional, submarginal, or incomplete or no data area, when such area is located in an ozone transport region.
- (c) 100 tons per year or more of nitrogen oxides in any area designated under Section 107(d) of the Act as attainment or unclassifiable for ozone that is located in an ozone transport region.
- (d) 50 tons per year or more of nitrogen oxides in any serious nonattainment area for ozone.
- (e) 25 tons per year or more of nitrogen oxides in any severe nonattainment area for ozone.
- (f) 10 tons per year or more of nitrogen oxides in any extreme nonattainment area for ozone; or

3. Any physical change that would occur at a stationary source not qualifying under subrule 31.3(1) as a major stationary source, if the change would constitute a major stationary source by itself.

4. A major stationary source that is major for volatile organic compounds shall be considered major for ozone.

5. The fugitive emissions of a stationary source shall not be included in determining for any of the purposes of this rule whether it is a major stationary source, unless the source belongs to one of the following categories of stationary sources: coal cleaning plants (with thermal dryers); kraft pulp mills; Portland cement plants; primary zinc smelters; iron and steel mills; primary aluminum ore reduction plants; primary copper smelters; municipal incinerators capable of charging more than 250 tons of refuse per day; hydrofluoric, sulfuric, or nitric acid plants; petroleum refineries; lime plants; phosphate rock processing plants; coke oven batteries; sulfur recovery plants; carbon black plants (furnace process); primary lead smelters; fuel conversion plants; sintering plants; secondary metal production plants; chemical process plants—The term chemical processing plant shall not include ethanol production facilities that produce ethanol by natural fermentation included in NAICS codes 325193 or 312140; fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input; petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels; taconite ore processing plants; glass fiber processing plants; charcoal production plants; fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input; and any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the Act.

*“Necessary preconstruction approvals or permits”* means those permits or approvals required under federal air quality control laws and regulations and those air quality control laws and regulations which are part of the SIP.

*“Net emissions increase”* means, with respect to any regulated NSR pollutant emitted by a major stationary source, the amount by which the sum of the following exceeds zero: the increase in emissions from a particular physical change or change in the method of operation at a stationary source as calculated according to the applicability requirements of paragraph 31.3(2) “b,” and any other increases and decreases in actual emissions at the major stationary source that are contemporaneous with the particular change and are otherwise creditable. Baseline actual emissions for calculating increases and decreases shall be determined as provided in the “baseline actual emissions” definition, except that paragraphs “1”(c) and “2”(d) shall not apply.

1. An increase or decrease in actual emissions is contemporaneous with the increase from the particular change only if the increase or decrease in actual emissions occurs between the date five years before construction on the particular change commences and the date that the increase from the particular change occurs;

2. An increase or decrease in actual emissions is creditable only if:

(a) The increase or decrease in actual emissions occurs within the contemporaneous time period, as noted in paragraph “1” of this definition; and

(b) The department has not relied on the increase or decrease in actual emissions in issuing a permit for the source under this rule, which permit is in effect when the increase in actual emissions from the particular change occurs; and

(c) Reserved.

3. An increase in actual emissions is creditable only to the extent that the new level of actual emissions exceeds the old level.

4. A decrease in actual emissions is creditable only to the extent that:

(a) The old level of actual emission or the old level of allowable emissions whichever is lower, exceeds the new level of actual emissions;

(b) It is enforceable as a practical matter at and after the time that actual construction on the particular change begins; and

(c) The department has not relied on a decrease in actual emissions in issuing any permit under regulations approved pursuant to 40 CFR Part 51, Subpart I, or has not relied on a decrease in actual emissions in demonstrating attainment or reasonable further progress;

(d) The decrease in actual emissions has approximately the same qualitative significance for public health and welfare as that attributed to the increase from the particular change; and

5. An increase that results from a physical change at a source occurs when the emissions unit on which construction occurred becomes operational and begins to emit a particular pollutant. Any replacement unit that requires shakedown becomes operational only after a reasonable shakedown period, not to exceed 180 days.

6. Actual emissions shall not apply for determining creditable increases and decreases or after a change.

*“Nonattainment major new source review (NSR) program”* means a major source preconstruction permit program that has been approved by the Administrator and incorporated into the plan to implement the requirements of this rule, or a program that implements 40 CFR Part 51, Appendix S, Sections I through VI, as amended on October 25, 2012. Any permit issued under such a program is a major NSR permit.

*“Pollution prevention”* means any activity that through process changes, product reformulation or redesign, or substitution of less polluting raw materials, eliminates or reduces the release of air pollutants (including fugitive emissions) and other pollutants to the environment prior to recycling, treatment, or disposal. “Pollution prevention” does not mean recycling (other than certain “in-process recycling” practices), energy recovery, treatment, or disposal.

*“Potential to emit”* means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only

if the limitation or the effect it would have on emissions is federally enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

*“Predictive emissions monitoring system”* or *“PEMS”* means all of the equipment necessary to monitor process and control device operational parameters (for example, control device secondary voltages and electric currents) and other information (for example, gas flow rate, O<sub>2</sub> or CO<sub>2</sub> concentrations), and calculate and record the mass emissions rate (for example, lb/hr) on a continuous basis.

*“Prevention of significant deterioration (PSD) permit”* means any permit that is issued under a major source preconstruction permit program that has been approved by the Administrator and incorporated into the plan to implement the requirements of 40 CFR 51.166, or under the program in 40 CFR 52.21.

*“Project”* means a physical change in, or change in the method of operation of, an existing major stationary source.

*“Projected actual emissions”* means the maximum annual rate, in tons per year, at which an existing emissions unit is projected to emit a regulated NSR pollutant in any one of the five years (12-month period) following the date the unit resumes regular operation after the project, or in any one of the ten years following that date, if the project involves increasing the emissions unit’s design capacity or its potential to emit of that regulated NSR pollutant and full utilization of the unit would result in a significant emissions increase or a significant net emissions increase at the major stationary source. In determining the projected actual emissions before beginning actual construction, the owner or operator of the major stationary source:

1. Shall consider all relevant information including, but not limited to, historical operational data, the company’s own representations, the company’s expected business activity and the company’s highest projections of business activity, the company’s filings with the state or federal regulatory authorities, and compliance plans under the approved plan; and

2. Shall include fugitive emissions to the extent quantifiable, and emissions associated with startups, shutdowns, and malfunctions; and

3. Shall exclude, in calculating any increase in emissions that results from the particular project, that portion of the unit’s emissions following the project that an existing unit could have accommodated during the consecutive 24-month period used to establish the baseline actual emissions and that are also unrelated to the particular project, including any increased utilization due to product demand growth; or

4. In lieu of using the method set out in paragraphs “1” through “3,” may elect to use the emissions unit’s potential to emit, in tons per year.

*“Reasonable period”* means an increase or decrease in actual emissions is contemporaneous with the increase from the particular change only if the increase or decrease in actual emissions occurs between the date five years before construction on the particular change commences and the date that the increase from the particular change occurs.

*“Regulated NSR pollutant”* means the following:

1. Nitrogen oxides or any volatile organic compounds;

2. Any pollutant for which a national ambient air quality standard has been promulgated;

3. Any pollutant that is identified as a constituent or precursor of a general pollutant listed under paragraph “1” or “2,” provided that such constituent or precursor pollutant may only be regulated under NSR as part of regulation of the general pollutant. Precursors identified by the Administrator for purposes of NSR are the following:

- (a) Volatile organic compounds and nitrogen oxides are precursors to ozone in all ozone nonattainment areas.

- (b) Sulfur dioxide is a precursor to PM<sub>2.5</sub> in all PM<sub>2.5</sub> nonattainment areas.

- (c) Nitrogen oxides are presumed to be precursors to PM<sub>2.5</sub> in all PM<sub>2.5</sub> nonattainment areas, unless the department demonstrates to the EPA’s satisfaction or EPA demonstrates that emissions of nitrogen oxides from sources in a specific area are not a significant contributor to the area’s ambient PM<sub>2.5</sub> concentrations.

- (d) Volatile organic compounds and ammonia are presumed not to be precursors to PM<sub>2.5</sub> in any PM<sub>2.5</sub> nonattainment area, unless the department demonstrates to the EPA’s satisfaction or EPA

demonstrates that emissions of volatile organic compounds or ammonia from sources in a specific area are a significant contributor to that area's ambient PM<sub>2.5</sub> concentrations; or

4. PM<sub>2.5</sub> emissions and PM<sub>10</sub> emissions shall include gaseous emissions from a source or activity which condense to form particulate matter at ambient temperatures.

*"Replacement unit"* means an emissions unit for which all the criteria listed in paragraphs "1" through "4" of this definition are met. No creditable emission reductions shall be generated from shutting down the existing emissions unit that is replaced.

1. The emissions unit is a reconstructed unit within the meaning of 40 CFR 60.15(b)(1) as amended through December 16, 1975, or the emissions unit completely takes the place of an existing emissions unit.

2. The emissions unit is identical to or functionally equivalent to the replaced emissions unit.

3. The replacement does not alter the basic design parameters of the process unit.

4. The replaced emissions unit is permanently removed from the major stationary source, otherwise permanently disabled, or permanently barred from operation by a permit that is enforceable as a practical matter. If the replaced emissions unit is brought back into operation, it shall constitute a new emissions unit.

*"Reviewing authority"* means the department of natural resources.

*"Secondary emissions"* means emissions which would occur as a result of the construction or operation of a major stationary source or major modification, but do not come from the major stationary source or major modification itself. For the purpose of this rule, "secondary emissions" must be specific, well defined, quantifiable, and impact the same general area as the stationary source or modification which causes the secondary emissions. "Secondary emissions" include emissions from any offsite support facility which would not be constructed or increase its emissions except as a result of the construction or operation of the major stationary source or major modification. "Secondary emissions" do not include any emissions which come directly from a mobile source such as emissions from the tailpipe of a motor vehicle, from a train, or from a vessel.

*"Significant"* means:

1. In reference to a net emissions increase or the potential of a source to emit any of the following pollutants, a rate of emissions that would equal or exceed any of the following rates:

Pollutant Emission Rate

(a) Carbon monoxide: 100 tons per year (tpy)

(b) Nitrogen oxides: 40 tpy

(c) Sulfur dioxide: 40 tpy

(d) Ozone: 40 tpy of volatile organic compounds or nitrogen oxides

(e) Lead: 0.6 tpy

(f) PM<sub>10</sub>: 15 tpy

(g) PM<sub>2.5</sub>: 10 tpy of direct PM<sub>2.5</sub> emissions; 40 tpy of sulfur dioxide emissions; 40 tpy of nitrogen oxide emissions unless the department demonstrates to EPA's satisfaction that the emissions of nitrogen oxides from sources in a specific area are not a significant contributor to the area's ambient PM<sub>2.5</sub> concentrations.

2. Notwithstanding the significant emissions rate for ozone, significant means, in reference to an emissions increase or a net emissions increase, any increase in actual emissions of volatile organic compounds that would result from any physical change in, or change in the method of operation of, a major stationary source locating in a serious or severe ozone nonattainment area that is subject to Subpart 2, Part D, Title I of the Act, if such emissions increase of volatile organic compounds exceeds 25 tons per year.

3. For the purposes of applying the requirements of subrule 31.3(8) to modifications at major stationary sources of nitrogen oxides located in an ozone nonattainment area or in an ozone transport region, the significant emission rates and other requirements for volatile organic compounds in paragraphs "1," "2," and "5" shall apply to nitrogen oxides emissions.

4. Notwithstanding the significant emissions rate for carbon monoxide, significant means, in reference to an emissions increase or a net emissions increase, any increase in actual emissions of

carbon monoxide that would result from any physical change in, or change in the method of operation of, a major stationary source in a serious nonattainment area for carbon monoxide if such increase equals or exceeds 50 tons per year, provided the department has determined that stationary sources contribute significantly to carbon monoxide levels in that area.

5. Notwithstanding the significant emissions rates for ozone under paragraphs “1” and “2,” any increase in actual emissions of volatile organic compounds from any emissions unit at a major stationary source of volatile organic compounds located in an extreme ozone nonattainment area that is subject to Subpart 2, Part D, Title I of the Act shall be considered a significant net emissions increase.

“*Significant emissions increase*” means, for a regulated NSR pollutant, an increase in emissions that is significant for that pollutant.

“*Stationary source*” means any building, structure, facility, or installation which emits or may emit a regulated NSR pollutant.

“*Temporary clean coal technology demonstration project*” means a clean coal technology demonstration project that is operated for a period of five years or less, and which complies with the SIP and other requirements necessary to attain and maintain the national ambient air quality standards during the project and after it is terminated.

“*Volatile organic compounds*” or “*VOC*” means any compound included in the definition of “volatile organic compounds” found at 40 CFR 51.100(s) as amended through January 21, 2009.

**31.3(2) Applicability procedures.**

*a.* This subrule adopts a preconstruction review program to satisfy the requirements of Sections 172(c)(5) and 173 of the Act for any area designated nonattainment for any national ambient air quality standard under Subpart C of 40 CFR Part 81 as amended on August 5, 2013, and shall apply to any new major stationary source or major modification that is major for the pollutant for which the area is designated nonattainment under Section 107(d)(1)(A)(i) of the Act, if the stationary source or modification would locate anywhere in the designated nonattainment area.

*b.* Each plan shall use the specific provisions of subparagraphs (1) through (6) of this paragraph. Deviations from these provisions will be approved only if the submitted provisions are more stringent than or at least as stringent in all respects as the corresponding provisions in subparagraphs (1) through (6) of this paragraph.

(1) Except as otherwise provided in paragraph 31.3(2)“c,” and consistent with the definition of major modification, a project is a major modification for a regulated NSR pollutant if it causes two types of emissions increases—a significant emissions increase and a significant net emissions increase. The project is not a major modification if it does not cause a significant emissions increase. If the project causes a significant emissions increase, then the project is a major modification only if it also results in a significant net emissions increase.

(2) The procedure for calculating (before beginning actual construction) whether a significant emissions increase (i.e., the first step of the process) will occur depends upon the type of emissions units being modified, according to subparagraphs (3) through (6) of this paragraph. The procedure for calculating (before beginning actual construction) whether a significant net emissions increase will occur at the major stationary source. Regardless of any such preconstruction projections, a major modification results if the project causes a significant emissions increase and a significant net emissions increase.

(3) Actual-to-projected-actual applicability test for projects that only involve existing emissions units. A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the difference between the projected actual emissions and the baseline actual emissions, for each existing emissions unit, equals or exceeds the significant amount for that pollutant.

(4) Actual-to-potential test for projects that only involve construction of a new emissions unit(s). A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the difference between the potential to emit from each new emissions unit following completion of the project and the baseline actual emissions of these units before the project equals or exceeds the significant amount for that pollutant.

(5) Reserved.

(6) Hybrid test for projects that involve multiple types of emissions units. A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the emissions increases for each emissions unit, using the method specified in subparagraphs (3) and (4) of this paragraph as applicable with respect to each emissions unit, for each type of emissions unit equals or exceeds the significant amount for that pollutant.

c. The plan shall require that for any major stationary source for a PAL for a regulated NSR pollutant, the major stationary source shall comply with requirements under rule 567—31.9(455B).

**31.3(3) Creditable offsets.**

a. For sources and modifications subject to any preconstruction review program, the baseline for determining credit for emissions reductions is the emissions limit in effect at the time the application to construct is filed, except that the offset baseline shall be the actual emissions of the source from which offset credit is obtained where;

(1) The demonstration of reasonable further progress and attainment of ambient air quality standards is based upon the actual emissions of sources located within a designated nonattainment area for which the preconstruction review program was adopted; or

(2) The SIP does not contain an emissions limitation for that source or source category.

b. Providing that:

(1) Where the emissions limit under the SIP allows greater emissions than the potential to emit of the source, emissions offset credit will be allowed only for control below this potential;

(2) For an existing fuel combustion source, credit shall be based on the allowable emissions under the SIP for the type of fuel being burned at the time the application to construct is filed. If the existing source commits to switch to a cleaner fuel at some future date, emissions offset credit based on the allowable (or actual) emissions for the fuels involved is not acceptable, unless the permit is conditioned to require the use of a specified alternative control measure which would achieve the same degree of emissions reduction should the source switch back to a dirtier fuel at some later date. The department should ensure that adequate long-term supplies of the new fuel are available before granting emissions offset credit for fuel switches,

(3) Emissions reductions achieved by shutting down an existing emission unit or curtailing production or operating hours may be generally credited for offsets if: such reductions are surplus, permanent, quantifiable, and federally enforceable; and the shutdown or curtailment occurred after the last day of the base year for the SIP planning process. For purposes of this subparagraph, the department may choose to consider a prior shutdown or curtailment to have occurred after the last day of the base year if the projected emissions inventory used to develop the attainment demonstration explicitly includes the emissions from such previously shutdown or curtailed emission units. However, in no event may credit be given for shutdowns that occurred before August 7, 1977.

Emissions reductions achieved by shutting down an existing emissions unit or curtailing production or operating hours and that do not meet the requirements above may be generally credited only if: the shutdown or curtailment occurred on or after the date the construction permit application is filed; or the applicant can establish that the proposed new emissions unit is a replacement for the shutdown or curtailed emissions unit, and the emissions reductions achieved by the shutdown or curtailment met the requirements of this subparagraph.

(4) No emissions credit may be allowed for replacing one hydrocarbon compound with another of lesser reactivity, except for those compounds listed in Table 1 of EPA's "Recommended Policy on Control of Volatile Organic Compounds" (42 FR 35314, July 8, 1977);

(5) All emission reductions claimed as offset credit shall be federally enforceable;

(6) Procedures relating to the permissible location of offsetting emissions shall be followed which are at least as stringent as those set out in 40 CFR Part 51, Appendix S, Section IV.D, as amended on October 25, 2012.

(7) Credit for an emissions reduction can be claimed to the extent that the department has not relied on it in issuing any permit under regulations approved pursuant to 40 CFR Part 51, Subpart I, or the state has not relied on it in demonstration attainment or reasonable further progress.

(8) Reserved.

(9) Reserved.

(10) The total tonnage of increased emissions, in tons per year, resulting from a major modification that must be offset in accordance with Section 173 of the Act shall be determined by summing the difference between the allowable emissions after the modification and the actual emissions before the modification for each emissions unit.

**31.3(4)** The department may provide that the provisions of this subrule do not apply to a source or modification that would be a major stationary source or major modification only if fugitive emissions, to the extent quantifiable, are considered in calculating the potential to emit of the stationary source or modification and the source does not belong to any of the following categories: coal cleaning plants (with thermal dryers); kraft pulp mills; Portland cement plants; primary zinc smelters; iron and steel mills; primary aluminum ore reduction plants; primary copper smelters; municipal incinerators capable of charging more than 250 tons of refuse per day; hydrofluoric, sulfuric, or nitric acid plants; petroleum refineries; lime plants; phosphate rock processing plants; coke oven batteries; sulfur recovery plants; carbon black plants (furnace process); primary lead smelters; fuel conversion plants; sintering plants; secondary metal production plants; chemical process plants—The term chemical processing plant shall not include ethanol production facilities that produce ethanol by natural fermentation included in NAICS codes 325193 or 312140; fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input; petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels; taconite ore processing plants; glass fiber processing plants; charcoal production plants; fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input; and any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the Act.

**31.3(5)** Enforceable procedures.

*a.* Approval to construct shall not relieve any owner or operator of the responsibility to comply fully with applicable provision of the plan and any other requirements under local, state or federal law.

*b.* At such time that a particular source or modification becomes a major stationary source or major modification solely by virtue of a relaxation in any enforcement limitation which was established after August 7, 1980, on the capacity of the source or modification otherwise to emit a pollutant, such as a restriction on hours of operation, then the requirements of this rule shall apply to the source or modification as though construction had not yet commenced on the source or modification.

**31.3(6)** Except as otherwise provided in paragraph 31.3(6) “*f*,” the following specific provisions apply with respect to any regulated NSR pollutant emitted from projects at existing emissions units at a major stationary source (other than projects at a source with a PAL) in circumstances where there is a reasonable possibility, within the meaning of paragraph 31.3(6) “*f*,” that a project that is not a part of a major modification may result in a significant emissions increase of such pollutant, and the owner or operator elects to use the method specified in paragraphs “1” through “3” of the definition of “projected actual emissions” for calculating projected actual emissions. Deviations from these provisions will be approved only if the state specifically demonstrates that the submitted provisions are more stringent than or at least as stringent in all respects as the corresponding provisions in paragraphs 31.3(6) “*a*” through “*f*.”

*a.* Before beginning actual construction of the project, the owner or operator shall document and maintain a record of the following information:

(1) A description of the project;

(2) Identification of the emissions unit(s) whose emissions of a regulated NSR pollutant could be affected by the project; and

(3) A description of the applicability test used to determine that the project is not a major modification for any regulated NSR pollutant, including the baseline actual emissions, the projected actual emissions, the amount of emissions excluded under paragraph “3” of the definition of “projected actual emissions” and an explanation for why such amount was excluded, and any netting calculations, if applicable.

*b.* If the emissions unit is an existing electric utility steam generating unit, before beginning actual construction, the owner or operator shall provide a copy of the information set out in paragraph

31.3(6) “a” to the department. Nothing in paragraph 31.3(6) “b” shall be construed to require the owner or operator of such a unit to obtain any determination from the reviewing authority before beginning actual construction.

c. The owner or operator shall monitor the emissions of any regulated NSR pollutant that could increase as a result of the project and that is emitted by any emissions units identified in subparagraph 31.3(6) “a”(2); and calculate and maintain a record of the annual emissions, in tons per year on a calendar year basis, for a period of five years following resumption of regular operations after the change, or for a period of ten years following resumption of regular operations after the change if the project increases the design capacity or potential to emit of that regulated NSR pollutant at such emissions unit.

d. If the unit is an existing electric utility steam generating unit, the owner or operator shall submit a report to the department within 60 days after the end of each year during which records must be generated under paragraph 31.3(6) “c” setting out the unit’s annual emissions during the year that preceded submission of the report.

e. If the unit is an existing unit other than an electric utility steam generating unit, the owner or operator shall submit a report to the department if the annual emissions, in tons per year, from the project identified in paragraph 31.3(6) “a,” exceed the baseline actual emissions (as documented and maintained under subparagraph 31.3(6) “a”(3)), by a significant amount for that regulated NSR pollutant, and if such emissions differ from the preconstruction projection as documented and maintained under subparagraph 31.3(6) “a”(3). Such report shall be submitted to the department within 60 days after the end of such year. The report shall contain the following:

- (1) The name, address and telephone number of the major stationary source;
- (2) The annual emissions as calculated pursuant to paragraph 31.3(6) “c”; and
- (3) Any other information that the owner or operator wishes to include in the report (e.g., an explanation as to why the emissions differ from the preconstruction projection).

f. A “reasonable possibility” under this subrule occurs when the owner or operator calculates the project to result in either:

(1) A projected actual emissions increase of at least 50 percent of the amount that is a “significant emissions increase” (without reference to the amount that is a significant net emissions increase) for the regulated NSR pollutant; or

(2) A projected actual emissions increase that, added to the amount of emissions excluded under paragraph “3” of the definition of “projected actual emissions,” sums to at least 50 percent of the amount that is a “significant emissions increase” (without reference to the amount that is a significant net emissions increase) for the regulated NSR pollutant. For a project for which a reasonable possibility occurs only within the meaning of this subparagraph, and not also within the meaning of subparagraph (1), then paragraphs 31.3(6) “b” through “e” do not apply to the project.

**31.3(7)** The owner or operator of the source shall make the information required to be documented and maintained pursuant to this subrule available for review upon a request for inspection by the department or the general public pursuant to the requirements contained in 40 CFR 70.4(b)(3)(viii) as amended through October 6, 2009.

**31.3(8)** The requirements of this subrule applicable to major stationary sources and major modifications of volatile organic compounds shall apply to nitrogen oxides emissions from major stationary sources and major modifications of nitrogen oxides in an ozone transport region or in any ozone nonattainment area, except in ozone nonattainment areas or in portions of an ozone transport region where the Administrator has granted a NO<sub>x</sub> waiver applying the standards set forth under Section 182(f) of the Act and the waiver continues to apply.

**31.3(9)** Offset ratios.

a. In meeting the emissions offset requirements of subrule 31.3(3), the ratio of total actual emissions reductions to the emissions increase shall be at least 1:1 unless an alternative ratio is provided for the applicable nonattainment area in paragraphs 31.3(9) “b” through “d.”

b. The plan shall require that in meeting the emissions offset requirements of subrule 31.3(3) for ozone nonattainment areas that are subject to Subpart 2, Part D, Title I of the Act, the ratio of total actual emissions reductions of VOC to the emissions increase of VOC shall be as follows:

- (1) In any marginal nonattainment area for ozone—at least 1.1:1;
- (2) In any moderate nonattainment area for ozone—at least 1.15:1;
- (3) In any serious nonattainment area for ozone—at least 1.2:1;
- (4) In any severe nonattainment area for ozone—at least 1.3:1 (except that the ratio may be at least 1.2:1 if the approved plan also requires all existing major sources in such nonattainment area to use BACT for the control of VOC); and
- (5) In any extreme nonattainment area for ozone—at least 1.5:1 (except that the ratio may be at least 1.2:1 if the approved plan also requires all existing major sources in such nonattainment area to use BACT for the control of VOC); and

*c.* Notwithstanding the requirements of subrule 31.3(9) for meeting the requirements of subrule 31.3(3), the ratio of total actual emissions reductions of VOC to the emissions increase of VOC shall be at least 1.15:1 for all areas within an ozone transport region that is subject to Subpart 2, Part D, Title I of the Act, except for serious, severe, and extreme ozone nonattainment areas that are subject to Subpart 2, Part D, Title I of the Act.

*d.* In meeting the emissions offset requirements of subrule 31.3(3) for ozone nonattainment areas that are subject to Subpart 1, Part D, Title I of the Act (but are not subject to Subpart 2, Part D, Title I of the Act, including eight-hour ozone nonattainment areas subject to 40 CFR 51.902(b)), the ratio of total actual emissions reductions of VOC to the emissions increase of VOC shall be at least 1:1.

**31.3(10)** The requirements of this rule applicable to major stationary sources and major modifications of PM<sub>10</sub> shall also apply to major stationary sources and major modifications of PM<sub>10</sub> precursors.

**31.3(11)** In meeting the emissions offset requirements of subrule 31.3(3), the emissions offsets obtained shall be for the same regulated NSR pollutant unless interprecursor offsetting is permitted for a particular pollutant as specified in this subrule. The offset requirements in subrule 31.3(3) for direct PM<sub>2.5</sub> emissions or emissions of precursors of PM<sub>2.5</sub> may be satisfied by offsetting reductions in direct PM<sub>2.5</sub> emissions or emissions of any PM<sub>2.5</sub> precursor if such offsets comply with the interprecursor trading hierarchy and ratio established in the approved plan for a particular nonattainment area.

[ARC 1227C, IAB 12/11/13, effective 1/15/14]

**567—31.4(455B) Preconstruction review permit program.**

**31.4(1)** Sources shall comply with the requirements of Section 110(a)(2)(D)(i) of the Act for any new major stationary source or major modification as defined in subrule 31.3(1). The definitions in subrule 31.3(1) for “major stationary source” and “major modification” planning to locate in any area designated as attainment or unclassifiable for any national ambient air quality standard pursuant to Section 107 of the Act, apply when that source or modification would cause or contribute to a violation of any national ambient air quality standard.

**31.4(2)** A major source or major modification will be considered to cause or contribute to a violation of a national ambient air quality standard when such source or modification would, at a minimum, exceed the following significance levels at any locality that does not or would not meet the applicable national standard:

Pollutant	Annual	Averaging time (hours)			
		24	8	3	1
SO <sub>2</sub>	1.0 µg/m <sup>3</sup>	5 µg/m <sup>3</sup>		25 µg/m <sup>3</sup>	
PM <sub>10</sub>	1.0 µg/m <sup>3</sup>	5 µg/m <sup>3</sup>			
PM <sub>2.5</sub>	0.3 µg/m <sup>3</sup>	1.2 µg/m <sup>3</sup>			
NO <sub>2</sub>	1.0 µg/m <sup>3</sup>				
CO			0.5 mg/m <sup>3</sup>		2 mg/m <sup>3</sup>

**31.4(3)** A proposed major source or major modification subject to this rule may reduce the impact of its emissions upon air quality by obtaining sufficient emission reductions to, at a minimum, compensate for its adverse ambient impact where the major source or major modification would otherwise cause or

contribute to a violation of any national ambient air quality standard. In the absence of such emission reductions, the proposed construction permit application shall be denied.

**31.4(4)** The requirements of this rule shall not apply to a major stationary source or major modification with respect to a particular pollutant if the owner or operator demonstrates that, as to that pollutant, the source or modification is located in an area designated as nonattainment pursuant to Section 107 of the Act.

[ARC 1227C, IAB 12/11/13, effective 1/15/14]

**567—31.5(455B) to 31.8(455B)** Reserved.

**567—31.9(455B) Actuals PALs.** Except as provided in subrule 31.9(1), the provisions for actuals PALs as specified in 40 CFR 51.165(f) as amended through March 30, 2011, are adopted by reference.

**31.9(1)** The following portions of actuals PALs in 40 CFR 51.165(f) are modified to read as follows:

*a.* 40 CFR 51.165(f)(2): Definitions. The definitions in paragraphs (f)(2)(i) through (xi) of this section shall be applicable to actuals PALs for purposes of paragraphs (f)(1) through (15) of this section. Any terms not defined in paragraphs (f)(2)(i) through (xi) shall have the meaning prescribed by rule 567—31.3(455B) or the meaning prescribed by the Act.

*b.* 40 CFR 51.165(f)(8)(ii)(B): The reviewing authority shall have discretion to reopen the PAL permit for the following:

*c.* 40 CFR 51.165(f)(10)(ii): Application deadline. A major stationary source owner or operator shall submit a timely application to the reviewing authority to request renewal of a PAL. In order to be considered timely, the application shall be submitted at least 6 months prior to, but not earlier than 18 months prior to, the date of permit expiration. This deadline for application submittal is to ensure that the permit will not expire before the permit is renewed. If the owner or operator of a major stationary source submits a complete application to renew the PAL within this time period, then the PAL shall continue to be effective until the revised permit with the renewed PAL is issued.

*d.* 40 CFR 51.165(f)(15)(i): Each PAL shall comply with the requirements contained in paragraphs (f)(1) through (15) of this section.

*e.* 40 CFR 51.165(f)(15)(ii): Any PAL issued prior to January 15, 2014, may be superseded with a PAL that complies with the requirements of paragraphs (f)(1) through (15) of this section.

**31.9(2)** Reserved.

[ARC 1227C, IAB 12/11/13, effective 1/15/14]

**567—31.10(455B) Validity of rules.** If any provision of rules 567—31.3(455B) through 567—31.9(455B), or the application of such provision to any person or circumstance, is held invalid, the remainder of these rules, or the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

[ARC 1227C, IAB 12/11/13, effective 1/15/14]

**567—31.11(455B) to 31.19(455B)** Reserved.

#### NONATTAINMENT AREAS DESIGNATED BEFORE MAY 18, 1998

**567—31.20(455B) Special requirements for nonattainment areas designated before May 18, 1998 (originally adopted in 567—22.5(455B)).**

**31.20(1) Definitions.**

*a.* “Major stationary source” means any of the following:

(1) Any stationary source of air contaminants which emits, or has the potential to emit, 100 tons per year or more of any regulated air contaminant;

(2) Any physical change that would occur at a stationary source not qualifying under subparagraph (1) as a major stationary source, if the change would constitute a major stationary source by itself;

(3) For ozone nonattainment areas, sources with the potential to emit 100 tpy or more of volatile organic compounds or oxides of nitrogen in areas classified as “marginal” or “moderate,” 50 tpy or more in areas classified as “serious,” 25 tpy or more in areas classified as “severe” and 10 tpy or more in areas

classified as “extreme”; except that the references in this paragraph to 100, 50, 25, and 10 tpy of nitrogen oxides shall not apply with respect to any source for which the Administrator has made a finding, under Section 182(f)(1) or (2) of the Clean Air Act, that requirements under Section 182(f) of the Clean Air Act do not apply;

(4) For ozone transport regions established pursuant to Section 184 of the Clean Air Act, sources with potential to emit 50 tpy or more of volatile organic compounds;

(5) For carbon monoxide nonattainment areas that both are classified as “serious” and in which there are stationary sources which contribute significantly to carbon monoxide levels, sources with the potential to emit 50 tpy or more of carbon monoxide; or

(6) For particulate matter (PM<sub>10</sub>), nonattainment areas classified as “serious,” sources with the potential to emit 70 tpy or more of PM<sub>10</sub>.

A major stationary source that is major for volatile organic compounds shall be considered major for ozone.

*b. “Major modification”* means any physical change in or change in the method of operation of a major stationary source, that would result in a significant net emission increase of any regulated air contaminant.

(1) Any net emissions increase that is considered significant for volatile organic compounds shall be considered significant for ozone.

(2) A physical change, or change in the method of operation, shall not include:

Routine maintenance, repair, and replacement;

Use of an alternative fuel or raw material by reason of an order under Sections 2(a) and (b) of the Energy Supply and Environmental Coordination Act of 1974 (or any superseding legislation), or by reason of a natural gas curtailment plan in effect pursuant to the Federal Power Act;

Use of an alternative fuel by reason of an order or rule under Section 125 of the Clean Air Act;

Any change in ownership at a stationary source;

Use of an alternative fuel at a steam generating unit to the extent that the fuel is generated from municipal solid waste;

Use of an alternative fuel or raw material by a stationary source which the source was capable of accommodating before December 21, 1976, unless such change would be prohibited by any enforceable permit condition; or

An increase in the hours of operation or in the production rate, unless such change is prohibited under any enforceable permit condition.

*c. “Potential to emit”* means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only if the limitation or the effect it would have on emissions is federally enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

The provisions of this paragraph do not apply to a source or modification that would be a major stationary source or major modification only if fugitive emissions, to the extent quantifiable, are considered in calculating the potential to emit of the stationary source or modification and the source does not belong to any of the following categories:

Coal cleaning plants (with thermal dryers);

Kraft pulp mills;

Portland cement plants;

Primary zinc smelters;

Iron and steel mills;

Primary aluminum ore reduction plants;

Primary copper smelters;

Municipal incinerators capable of charging more than 250 tons of refuse per day;

Hydrofluoric, sulfuric, or nitric acid plants;

Petroleum refineries;

Lime plants;  
Phosphate rock processing plants;  
Coke oven batteries;  
Sulfur recovery plants;  
Carbon black plants (furnace process);  
Primary lead smelters;  
Fuel conversion plants;  
Sintering plants;  
Secondary metal production plants;  
Chemical process plants;  
Fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input;  
Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels;  
Taconite ore processing plants;  
Glass fiber processing plants;  
Charcoal production plants;  
Fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input;

Any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the Clean Air Act, 42 U.S.C. §§7401 et seq.

*d. "Lowest achievable emission rate"* means, for any source, that rate of emissions based on the following, whichever is more stringent:

(1) The most stringent emission limitation which is contained in the implementation plan of any state for such class or category of stationary source, unless the owner or operator of the proposed stationary source demonstrates that such limitations are not achievable; or

(2) The most stringent emission limitation which is achieved in practice by such class or category of source.

This term, applied to a modification, means the lowest achievable emission rate for the new or modified emission units within the stationary source.

This term may include a design, equipment, material, work practice or operational standard or combination thereof.

In no event shall the application of this term permit a proposed new or modified stationary source to emit any regulated air contaminant in excess of the amount allowable under applicable new source standards of performance.

*e. "Secondary emissions"* means emissions which occur or could occur as a result of the construction or operation of a major stationary source or major modification, but do not necessarily come from the major stationary source or major modification itself. For purposes of this rule, secondary emissions must be specific and well-defined, must be quantifiable, and must affect the same general nonattainment area as the stationary source or modification which causes the secondary emission. Secondary emissions may include, but are not limited to:

Emissions from barges or trains coming to or from the new or modified stationary source; and

Emissions from any off-site support facility which would not otherwise be constructed or increase its emissions as a result of the construction or operation of the major stationary source or major modification.

*f. (1) "Net emissions increase"* means the amount by which the sum of the following exceeds zero:

Any increase in actual emissions from a particular physical change or change in the method of operation at a stationary source; and

Any other increases and decreases in actual emissions at the source that are contemporaneous with the particular change and are otherwise creditable.

(2) An increase or decrease in actual emissions is contemporaneous with the increase from the particular change only if it occurs between the date five years before construction on the particular change commences and the date that the increase from the particular change occurs.

(3) An increase or decrease in actual emissions is creditable only if the director has not relied on it in issuing a permit for the source under this rule which permit is in effect when the increase in actual emissions from the particular change occurs.

(4) An increase in actual emissions is creditable only to the extent that the new level of actual emissions exceeds the old level.

(5) A decrease in actual emissions is creditable only to the extent that:

The old level of actual emissions or the old level of allowable emissions, whichever is lower, exceeds the new level of actual emissions;

It is an enforceable permit condition at and after the time that actual construction on the particular change begins;

The director has not relied on it in issuing any other permit;

Such emission decreases have not been used for showing reasonable further progress; and

It has approximately the same qualitative significance for public health and welfare as that attributed to the increase from the particular change.

(6) An increase that results from a physical change at a source occurs when the emissions unit on which construction occurred becomes operational and begins to emit a particular pollutant. Any replacement unit that requires shakedown becomes operational only after a reasonable shakedown period, not to exceed 180 days.

*g.* “Emissions unit or installation” means an identifiable piece of process equipment.

*h.* “Reconstruction” will be presumed to have taken place where the fixed capital cost of the new components exceeds 50 percent of the fixed capital cost of a comparable entirely new stationary source. Any final decision as to whether reconstruction has occurred shall be made in accordance with the provisions of new source performance standards (see 567—subrule 23.1(2)). A reconstructed stationary source will be treated as a new stationary source for purposes of this rule. In determining lowest achievable emission rate for a reconstructed stationary source, the definitions in the new source performance standards shall be taken into account in assessing whether a new source performance standard is applicable to such stationary source.

*i.* “Fixed capital cost” means the capital needed to provide all the depreciable components.

*j.* “Fugitive emissions” means those emissions which could not reasonably pass through a stack, chimney, vent, or other functionally equivalent opening.

*k.* “Significant” means in reference to a net emissions increase or the potential of a source to emit any of the following pollutants, a rate of emissions that would equal or exceed any of the following rates:

Pollutant and Emissions Rate

Carbon monoxide: 100 tons per year (tpy)

Nitrogen oxides: 40 tpy

Sulfur dioxide: 40 tpy

Particulate matter: 25 tpy

Ozone: 40 tpy of volatile organic compounds

Lead: 0.6 tpy

PM<sub>10</sub>: 15 tpy

*l.* “Allowable emissions” means the emissions rate calculated using the maximum rated capacity of the source (unless the source is subject to an enforceable permit condition which restricts the operating rate, or hours of operation, or both) and the most stringent of the following:

(1) Applicable standards as set forth in 567—Chapter 23;

(2) Any applicable state implementation plan emissions limitation, including those with a future compliance date; or

(3) The emissions rate specified as an enforceable permit condition, including those with a future compliance date.

*m.* “Enforceable permit condition” for the purpose of this rule means any of the following limitations and conditions: requirements developed pursuant to new source performance standards, prevention of significant deterioration standards, emission standards for hazardous air pollutants,

requirements within the state implementation plan, and any permit requirements established pursuant to this rule, or under construction or Title V operating permit rules.

*n.* (1) “*Actual emissions*” means the actual rate of emissions of a pollutant from an emissions unit as determined in accordance with subparagraphs (2) to (4) below.

(2) In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a two-year period which precedes the particular date and which is representative of normal source operation. The reviewing authority shall allow the use of a different time period upon a determination that it is more representative of normal source operation. Actual emissions shall be calculated using the unit’s actual operating hours, production rates, and types of materials processed, stored or combusted during the selected time period.

(3) The director may presume that source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

(4) For any emissions unit which has not begun normal operations on the particular date, actual emissions shall equal the potential to emit of the unit on that date.

*o.* “*Construction*” means any physical change or change in the method of operation (including fabrication, erection, installation, demolition, or modification of an emissions unit) which would result in a change in actual emissions.

*p.* “*Commence*” as applied to construction of a major stationary source or major modification means that the owner or operator has all necessary preconstruction approvals or permits and either has:

(1) Begun, or caused to begin, a continuous program of actual on-site construction of the source, to be completed within a reasonable time; or

(2) Entered into binding agreements or contractual obligations, which cannot be canceled or modified without substantial loss to the owner or operator, to undertake a program of actual construction of the source to be completed within a reasonable time.

*q.* “*Necessary preconstruction approvals or permits*” means those permits or approvals required under federal air quality control laws and regulations and those air quality control laws and regulations which are part of the state implementation plan.

*r.* “*Begin actual construction*” means, in general, initiation of physical on-site construction activities on an emissions unit which are of a permanent nature. Such activities include, but are not limited to, installation of building supports and foundations, laying of underground pipework and construction of permanent storage structures. With respect to a change in method of operating, this term refers to those on-site activities other than preparatory activities which mark the initiation of the change.

*s.* “*Building, structure, or facility*” means all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control). Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same “major group” (i.e., which have the same two-digit code) as described in the Standard Industrial Classification Manual, 1972, as amended by the 1977 Supplement (U.S. Government Printing Office stock numbers 4101-0066 and 003-005-00176-0 respectively).

**31.20(2) Applicability.** Areas designated as attainment, nonattainment, or unclassified are as listed in 40 CFR §81.316 as amended through March 19, 1998.

*a.* The requirements contained in rule 567—31.20(455B) shall apply to any new major stationary source or major modification that, as of the date the permit is issued, is major for any pollutant for which the area in which the source would construct is designated as nonattainment.

*b.* The requirements contained in rule 567—31.20(455B) shall apply to each nonattainment pollutant that the source will emit or has the potential to emit in major amounts. In the case of a modification, the requirements shall apply to the significant net emissions increase of each nonattainment pollutant for which the source is major.

*c.* Particulate matter. If a major source or major modification is proposed to be constructed in an area designated nonattainment for particulate matter, then emission offsets must be achieved prior to startup.

If a major source or major modification is proposed to be constructed in an area designated attainment or unclassified for particulate matter, but the modeled (EPA-approved guideline model) worst case ground level particulate concentrations due to the major source or major modification in a designated particulate matter nonattainment area is equal to or greater than five micrograms per cubic meter (24-hour concentration), or one microgram per cubic meter (annual arithmetic mean), then emission offsets must be achieved prior to startup.

*d.* Sulfur dioxide. If a major source or major modification is proposed to be constructed in an area designated nonattainment for sulfur dioxide, then emission offsets must be achieved prior to startup.

If a major source or major modification is proposed to be constructed in an area designated attainment or unclassified for sulfur dioxide, but the modeled (EPA-approved guideline model) worst case ground level sulfur dioxide concentrations due to the major source or major modification in a designated sulfur dioxide nonattainment area is equal to or greater than 25 micrograms per cubic meter (three-hour concentration), five microgram per cubic meter (24-hour concentration), or one microgram per cubic meter (annual arithmetic mean), then emission offsets must be achieved prior to startup.

*e.* At such time that a particular source or modification becomes a major stationary source or major modification solely by virtue of a relaxation in any enforceable limitation which was established after August 7, 1980, on the capacity of the source or modification otherwise to emit a pollutant, such as a restriction on hours of operation, then the requirements of this rule shall apply to the source or modification as though construction had not yet commenced on the source or modification.

**31.20(3) Emission offsets.**

*a.* Emission offsets shall be obtained from the same source or other sources in the same nonattainment area, except that the required emissions reductions may be obtained from a source in another nonattainment area if:

(1) The other area, which must be nonattainment for the same pollutant, has an equal or higher nonattainment classification than the nonattainment area in which the source is located, and

(2) Emissions from such other nonattainment areas contribute to a violation of a national ambient air quality standard in the nonattainment area in which the proposed new or modified source would construct.

*b.* Emission offsets for any regulated air contaminant in the designated nonattainment area shall provide for reasonable further progress toward attainment of the applicable national ambient air quality standards and provide a positive net air quality benefit in the nonattainment area.

*c.* The increased emissions of any applicable nonattainment air pollutant allowed from the proposed new or modified source shall be offset by an equal or greater reduction, as applicable, in the total tonnage and impact of actual emissions, as stated in subrule 31.20(4), of such air pollutant from the same or other sources. For purposes of subrule 31.20(3), actual emissions shall be determined in accordance with subparagraphs 31.20(1) "n"(1) and (2).

*d.* All emissions reductions claimed as offset credit shall be federally enforceable prior to, or upon, the issuance of the permit required under this rule and shall be in effect by the time operation of the permitted new source or modification begins.

*e.* Proposals for emission offsets shall be submitted with the application for a permit for the major source or major modification. All approved emission offsets shall be made a part of the permit and shall be deemed a condition of expected performance of the major source or major modification.

**31.20(4) Acceptable emission offsets.**

*a.* *Equivalence.* The effect of the reduction of emissions must be measured or predicted to occur in the same area as the emissions of the major source or major modification. It can be assumed that, if the emission offsets are obtained from an existing source on the same premises or in the immediate vicinity of the major source or major modification and if the air contaminant disperses from substantially the same stack height, the emissions will be equivalent and may be offset. Otherwise, an adequate dispersion model must be used to predict the effect. If the reduction accomplished at the source is as specified in subrule 31.20(3) and if the effect of the reduction is measured or predicted to occur in the same area as the emissions of the major source or major modification, the effect of the reduction at the measured or predicted point does not have to exactly offset the effect of the major source or major modification.

b. Reserved.

c. *Control of uncontrolled existing sources.* If control equipment is proposed for a presently uncontrolled existing source for which controls are not required by rules, then credit may be allowed for any reduction below the source's potential to emit. The reduction shall be proposed at the time of permit application. Any such reductions which occurred prior to January 1, 1978, shall not be accepted for offsets.

d. *Greater control of existing sources.* If more effective control equipment for a source already in compliance with the SIP allowable level is proposed to offset the emissions of the major source or major modification in or affecting a nonattainment area, then the difference in the emissions between the actual level on January 1, 1978, and the new level can be credited for offsets. (This does not allow credit to be granted for any reductions in actual emissions required by the SIP subsequent to January 1, 1978.)

For example, if a cyclone that is being used to meet a SIP emission standard is emitting  $x_1$  lbs/hr and if it is to be replaced by a bag filter emitting  $x_2$  lbs/hr, an emission offset equal to  $(x_1 - x_2)$  lbs/hr may be allowed toward the total required reduction.

e. *Fugitive dust offsets.* Credits may be allowed for permanent control of fugitive dust. EPA's "Technical Guidance for Control of Industrial Process Fugitive Particulate Emissions" (EPA-450/3-77-010, March 1977) shall be used as a guide to estimate reduction from fugitive dust controls on traditional sources. Traditional source means a source category for which a particulate emission standard has been established in 567—subrule 23.1(2), 567—paragraph 23.3(2) "a" or "b" or 567—23.4(455B). The emission factors shall be modified to reflect realistic reductions. This would correspond to a consideration of particles in the less than 3 micron size range and the effectiveness of the fugitive dust control method.

f. *Fuel switching credits.* Credit may be allowed for fuel switching provided there is a demonstration by the applicant that supplies of the cleaner fuel will be available to the applicant for a minimum of five years. The demonstration must include, as a minimum, a written contract with the fuel supplier that the fuel will not be interrupted. The permit for the existing source shall be amended to provide for maintaining those offsets resulting from the fuel switching before offset credit will be granted.

g. *Reduction credits.* Credit for an emissions reduction can be claimed to the extent that the Administrator and the department have not: (1) relied on it in issuing any permit under regulations approved pursuant to 40 CFR Parts 51 (amended through April 9, 1998), 55 (amended through August 4, 1997), 63 (amended through December 28, 1998), 70 (amended through November 26, 1997), or 71 (amended through October 22, 1997); (2) relied on it in demonstrating attainment or reasonable further progress; or (3) the reduction is not otherwise required under the Clean Air Act. Incidental emissions reductions which are not otherwise required under the Act shall be creditable as emissions reductions for such purposes if such emissions reductions meet the requirements of subrule 31.20(3).

h. *Derating of equipment.* If the emissions from a major source or major modification are proposed to be offset by reducing the operating capacity of another existing source, then credit may be allowed for this provided proper documentation (such as stack test results) showing the effect on emissions due to derating is submitted. The permit for the existing source must be amended to limit the operating capacity before offsets will be allowed.

i. *Shutdown or curtailment.*

(1) Emissions reductions achieved by shutting down an existing source or curtailing production or operating hours below baseline levels may be generally credited if such reductions are surplus, permanent, quantifiable, and federally enforceable, and if the area has an EPA-approved attainment plan. In addition, the shutdown or curtailment is creditable only if it occurred on or after the date specified for this purpose in the plan, and if such date is on or after the date of the most recent emissions inventory or attainment demonstration. However, in no event may credit be given for shutdowns which occurred prior to January 1, 1978. For purposes of this paragraph, the director may consider a prior shutdown or curtailment to have occurred after the date of its most recent emissions inventory, if the inventory explicitly includes as current existing emissions the emissions from such previously shutdown

or curtailed sources. The work force shall be notified of the proposed curtailment or shutdown by the source owner or operator.

(2) The reductions described in subparagraph 31.20(4)“i”(1) may be credited in the absence of any approved attainment demonstration only if the shutdown or curtailment occurred on or after the date the new source permit application is filed, or, if the applicant can establish that the proposed new source is a replacement for the shutdown or curtailed source, and the cutoff date provisions in 31.20(4)“i”(1) are observed.

*j. External emission offsets.* If the emissions from the major source or major modification are proposed to be offset by reduction of emissions from a source not owned or operated by the owner or operator of the major source or major modification, then credit may be allowed for such reductions provided the external source's permit is amended to require the reduced emissions or a consent order is entered into by the department and the existing source. Consent orders for external offsets must be incorporated into the SIP and be approved by EPA before offset credit may be granted.

**31.20(5) Banking of offsets in nonattainment areas.** If the offsets in a given situation are more than required by 31.20(3), the amount of offsets that is greater than required may be banked for the exclusive use or control of the person achieving the reduction, subject to the limitations of this subrule. If the person achieving the reduction is not an individual, an authorized representative of the person must release control of the banked emissions in writing before another person, other than the commission, can utilize the banked emissions. The banking of offsets creates no property right in those offsets. The commission may proportionally reduce or cancel banked offsets if it is determined that reduction or cancellation is necessary to demonstrate reasonable further progress or to attain the ambient air quality standards. Prior to reduction or cancellation, the commission shall notify the person who banked the offsets.

**31.20(6) Control technology review.**

*a. Lowest achievable emission rate.* A new or modified major source in a nonattainment area shall comply with the lowest achievable emission rate.

*b. For phased construction projects,* the determination of the lowest achievable emissions rate shall be reviewed and modified as appropriate at the latest reasonable time which occurs no later than 18 months prior to the commencement of construction of each independent phase of the project. At such time, the owner or operator of the applicable stationary source may be required to demonstrate the adequacy of any previous determination of the LAER for the source.

*c. State implementation plan, new source performance standards, and emission standards for hazardous air pollutants.* A major stationary source or major modification shall meet each applicable emissions limitation under the state implementation plan and each applicable emissions standard of performance under 40 CFR Parts 60 (amended through November 24, 1998), 61 (amended through October 14, 1997), and 63 (amended through December 28, 1998).

**31.20(7) Compliance of existing sources.** If a new major source or major modification is subject to rule 567—31.20(455B), then all major sources owned or operated by the applicant (or by any entity controlling, controlled by, or under common control by the applicant) in Iowa shall be either in compliance with applicable emission standards or under a compliance schedule approved by the commission.

**31.20(8) Alternate site analysis.** The permit application shall contain a submittal of an alternative site analysis. Such submittal shall include analysis of alternative sites, sizes, production processes and environmental control techniques for the proposed source. The analysis must demonstrate that benefits of the proposed source significantly outweigh the environmental and social costs that would result from its location, construction or modification. Such analysis shall be completed prior to permit issuance.

**31.20(9) Additional conditions for permit approval.**

*a. For the air pollution control requirements applicable to subrule 31.20(6),* the permit shall require the source to monitor, keep records, and provide reports necessary to determine compliance with and deviations from applicable requirements.

*b. The state shall not issue the permit if the Administrator has determined that the applicable implementation plan is not being adequately implemented for the nonattainment area in which the proposed stationary source or modification is to be constructed.*

**31.20(10) *Public availability of information.*** No permit shall be issued until notice and opportunity for public comment are made available in accordance with the procedure described in 40 CFR 51.161 (as amended through November 7, 1986).

[ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 1913C, IAB 3/18/15, effective 4/22/15]

These rules are intended to implement Iowa Code section 455B.133.

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[Filed ARC 1227C (Notice ARC 1016C, IAB 9/18/13), IAB 12/11/13, effective 1/15/14]

[Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]

[Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective 12/16/15]



CHAPTER 33  
SPECIAL REGULATIONS AND CONSTRUCTION PERMIT REQUIREMENTS  
FOR MAJOR STATIONARY SOURCES—PREVENTION OF SIGNIFICANT  
DETERIORATION (PSD) OF AIR QUALITY

**567—33.1(455B) Purpose.** This chapter implements the major New Source Review (NSR) program contained in Part C of Title I of the federal Clean Air Act as amended on November 15, 1990, and as promulgated under 40 CFR 51.166 and 52.21 as amended through July 20, 2011. This is a preconstruction review and permitting program applicable to new or modified major stationary sources of air pollutants regulated under Part C of the Clean Air Act as amended on November 15, 1990. In areas that do not meet the national ambient air quality standards (NAAQS), the nonattainment major program applies. The requirements for the nonattainment major NSR program are set forth in 567—22.5(455B), 567—22.6(455B), 567—31.20(455), and 567—31.3(455B). In areas that meet the NAAQS, the PSD program applies. Collectively, the nonattainment major and PSD programs are referred to as the major NSR program. An owner or operator required to apply for a construction permit under 567—Chapter 33 shall submit fees as required in 567—Chapter 30.

Rule 567—33.2(455B) is reserved.

Rule 567—33.3(455B) sets forth the definitions, standards and permitting requirements that are specific to the PSD program.

Rules 567—33.4(455B) through 567—33.8(455B) are reserved.

Rule 567—33.9(455B) includes the conditions under which a source subject to PSD may obtain a plantwide applicability limitation (PAL) on emissions. An owner or operator requesting a PAL under 567—33.9(455B) shall submit fees as required in 567—Chapter 30.

In addition to the requirements in this chapter, stationary sources may also be subject to the permitting requirements in 567—Chapter 22, including requirements for Title V operating permits.

[ARC 9906B, IAB 12/14/11, effective 11/16/11; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—33.2(455B)** Reserved.

**567—33.3(455B) Special construction permit requirements for major stationary sources in areas designated attainment or unclassified (PSD).**

**33.3(1) Definitions.** Definitions included in this subrule apply to the provisions set forth in this rule (PSD program requirements). For purposes of this rule, the definitions herein shall apply, rather than the definitions contained in 40 CFR 52.21 and 51.166, except for the PAL program definitions referenced in rule 567—33.9(455B). For purposes of this rule, the following terms shall have the meanings indicated in this subrule:

“*Act*” means the Clean Air Act, 42 U.S.C. Sections 7401, et seq., as amended through November 15, 1990.

“*Actual emissions*” means:

1. The actual rate of emissions of a regulated NSR pollutant from an emissions unit, as determined in accordance with paragraphs “2” through “4,” except that this definition shall not apply for calculating whether a significant emissions increase has occurred, or for establishing a PAL under rule 567—33.9(455B). Instead, the requirements specified under the definitions for “projected actual emissions” and “baseline actual emissions” shall apply for those purposes.

2. In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a consecutive 24-month period which precedes the particular date and which is representative of normal source operation. The department shall allow the use of a different time period upon a determination that it is more representative of normal source operation. Actual emissions shall be calculated using the unit’s actual operating hours, production rates, and types of materials processed, stored, or combusted during the selected time period.

3. The department may presume that source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

4. For any emissions unit that has not begun normal operations on the particular date, actual emissions shall equal the potential to emit of the unit on that date.

“*Administrator*” means the administrator for the United States Environmental Protection Agency (EPA) or designee.

“*Allowable emissions*” means the emissions rate of a stationary source calculated using the maximum rated capacity of the source (unless the source is subject to federally enforceable limits or enforceable permit conditions which restrict the operating rate, or hours of operation, or both) and the most stringent of the following:

1. The applicable standards as set forth in 567—subrules 23.1(2) through 23.1(5) (new source performance standards, emissions standards for hazardous air pollutants, and federal emissions guidelines) or an applicable federal standard not adopted by the state, as set forth in 40 CFR Parts 60, 61 and 63;

2. The applicable state implementation plan (SIP) emissions limitation, including those with a future compliance date; or

3. The emissions rate specified as an enforceable permit condition, including those with a future compliance date.

“*Baseline actual emissions,*” for the purposes of this chapter, means the rate of emissions, in tons per year, of a regulated NSR pollutant, as “regulated NSR pollutant” is defined in this subrule, and as determined in accordance with paragraphs “1” through “4.”

1. For any existing electric utility steam generating unit, “baseline actual emissions” means the average rate, in tons per year, at which the unit actually emitted the pollutant during any consecutive 24-month period selected by the owner or operator within the five-year period immediately preceding the date on which the owner or operator begins actual construction of the project. The department shall allow the use of a different time period upon a determination that it is more representative of normal source operation.

(a) The average rate shall include fugitive emissions to the extent quantifiable and emissions associated with startups, shutdowns, and malfunctions.

(b) The average rate shall be adjusted downward to exclude any noncompliant emissions that occurred while the source was operating above an emissions limitation that was legally enforceable during the consecutive 24-month period.

(c) For a regulated NSR pollutant, when a project involves multiple emissions units, only one consecutive 24-month period must be used to determine the baseline actual emissions for the emissions units being changed. A different consecutive 24-month period may be used for each regulated NSR pollutant.

(d) The average rate shall not be based on any consecutive 24-month period for which there is inadequate information for determining annual emissions, in tons per year, and for adjusting this amount if required by paragraph “1”(b) of this definition.

2. For an existing emissions unit, other than an electric utility steam generating unit, “baseline actual emissions” means the average rate, in tons per year, at which the emissions unit actually emitted the pollutant during any consecutive 24-month period selected by the owner or operator within the ten-year period immediately preceding either the date on which the owner or operator begins actual construction of the project, or the date on which a complete permit application is received by the department for a permit required either under this chapter or under a SIP approved by the Administrator, whichever is earlier, except that the ten-year period shall not include any period earlier than November 15, 1990.

(a) The average rate shall include fugitive emissions to the extent quantifiable and emissions associated with startups, shutdowns, and malfunctions.

(b) The average rate shall be adjusted downward to exclude any noncompliant emissions that occurred while the source was operating above an emissions limitation that was legally enforceable during the consecutive 24-month period.

(c) The average rate shall be adjusted downward to exclude any emissions that would have exceeded an emissions limitation with which the major stationary source must currently comply, had such major stationary source been required to comply with such limitations during the consecutive

24-month period. However, if an emissions limitation is part of a maximum achievable control technology standard that the Administrator proposed or promulgated under 40 CFR Part 63, the baseline actual emissions need only be adjusted if the state has taken credit for such emissions reductions in an attainment demonstration or maintenance plan consistent with the requirements of 40 CFR 51.165(a)(3)(ii)(G) as amended through November 29, 2005.

(d) For a regulated NSR pollutant, when a project involves multiple emissions units, only one consecutive 24-month period must be used to determine the baseline actual emissions for the emissions units being changed. A different consecutive 24-month period may be used for each regulated NSR pollutant.

(e) The average rate shall not be based on any consecutive 24-month period for which there is inadequate information for determining annual emissions, in tons per year, and for adjusting this amount if required by paragraphs “2”(b) and “2”(c) of this definition.

3. For a new emissions unit, the baseline actual emissions for purposes of determining the emissions increase that will result from the initial construction and operation of such unit shall equal zero; and thereafter, for all other purposes, shall equal the unit’s potential to emit.

4. For a PAL for a stationary source, the baseline actual emissions shall be calculated for existing electric utility steam generating units in accordance with the procedures contained in paragraph “1”; for other existing emissions units in accordance with the procedures contained in paragraph “2”; and for a new emissions unit in accordance with the procedures contained in paragraph “3.”

*“Baseline area”* means:

1. Any intrastate area (and every part thereof) designated as attainment or unclassifiable under Section 107(d)(1)(A)(ii) or (iii) of the Act in which the major source or major modification establishing the minor source baseline date would construct or would have an air quality impact for the pollutant for which the baseline date is established, as follows: equal to or greater than 1  $\mu\text{g}/\text{m}^3$  (annual average) for sulfur dioxide ( $\text{SO}_2$ ), nitrogen dioxide ( $\text{NO}_2$ ) or  $\text{PM}_{10}$ ; or equal to or greater than 0.3  $\mu\text{g}/\text{m}^3$  (annual average) for  $\text{PM}_{2.5}$ .

2. Area redesignations under Section 107(d)(1)(A)(ii) or (iii) of the Act cannot intersect or be smaller than the area of impact of any major stationary source or major modification which establishes a minor source baseline date or is subject to regulations specified in this rule, in 40 CFR 52.21 (PSD requirements), or in department rules approved by EPA under 40 CFR Part 51, Subpart I, and would be constructed in the same state as the state proposing the redesignation.

3. Any baseline area established originally for the total suspended particulate increments shall remain in effect and shall apply for purposes of determining the amount of available  $\text{PM}_{10}$  increments, except that such baseline area shall not remain in effect if the permitting authority rescinds the corresponding minor source baseline date in accordance with the definition of “baseline date” specified in this subrule.

*“Baseline concentration”* means:

1. The ambient concentration level that exists in the baseline area at the time of the applicable minor source baseline date. A baseline concentration is determined for each pollutant for which a minor source baseline date is established and shall include:

(a) The actual emissions representative of sources in existence on the applicable minor source baseline date, except as provided in paragraph “2” of this definition;

(b) The allowable emissions of major stationary sources that commenced construction before the major source baseline date, but were not in operation by the applicable minor source baseline date.

2. The following will not be included in the baseline concentration and will affect the applicable maximum allowable increase(s):

(a) Actual emissions from any major stationary source on which construction commenced after the major source baseline date; and

(b) Actual emissions increases and decreases at any stationary source occurring after the minor source baseline date.

*“Baseline date”* means:

1. Either “major source baseline date” or “minor source baseline date” as follows:

(a) The “major source baseline date” means, in the case of PM<sub>10</sub> and sulfur dioxide, January 6, 1975; in the case of nitrogen dioxide, February 8, 1988; and in the case of PM<sub>2.5</sub>, October 20, 2010.

(b) The “minor source baseline date” means the earliest date after the trigger date on which a major stationary source or a major modification subject to 40 CFR 52.21 as amended through October 20, 2010, or subject to this rule (PSD program requirements), or subject to a department rule approved by EPA under 40 CFR Part 51, Subpart I, submits a complete application under the relevant regulations. The trigger date for PM<sub>10</sub> and sulfur dioxide is August 7, 1977. For nitrogen dioxide, the trigger date is February 8, 1988. For PM<sub>2.5</sub>, the trigger date is October 20, 2011.

2. The “baseline date” is established for each pollutant for which increments or other equivalent measures have been established if:

(a) The area in which the proposed source or modification would construct is designated as attainment or unclassifiable under Section 107(d)(1)(A)(ii) or (iii) of the Act for the pollutant on the date of its complete application under 40 CFR 52.21 as amended through October 20, 2010, or under regulations specified in this rule (PSD program requirements); and

(b) In the case of a major stationary source, the pollutant would be emitted in significant amounts, or in the case of a major modification, there would be a significant net emissions increase of the pollutant.

Any minor source baseline date established originally for the total suspended particulate increments shall remain in effect and shall apply for purposes of determining the amount of available PM<sub>10</sub> increments, except that the reviewing authority may rescind any such minor source baseline date where it can be shown, to the satisfaction of the reviewing authority, that the emissions increase from the major stationary source, or the net emissions increase from the major modification, responsible for triggering that date did not result in a significant amount of PM<sub>10</sub> emissions.

“*Begin actual construction*” means, in general, initiation of physical on-site construction activities on an emissions unit which are of a permanent nature. Such activities include, but are not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures. With respect to a change in method of operation, this term refers to those on-site activities, other than preparatory activities, which mark the initiation of the change.

“*Best available control technology*” or “*BACT*” means an emissions limitation, including a visible emissions standard, based on the maximum degree of reduction for each regulated NSR pollutant which would be emitted from any proposed major stationary source or major modification which the reviewing authority, on a case-by-case basis, taking into account energy, environmental, and economic impacts and other costs, determines is achievable for such source or modification through application of production processes or available methods, systems, and techniques, including fuel cleaning or treatment or innovative fuel combination techniques for control of such pollutant. In no event shall application of best available control technology result in emissions of any pollutant which would exceed the emissions allowed by any applicable standard under 567—subrules 23.1(2) through 23.1(5) (standards for new stationary sources, federal standards for hazardous air pollutants, and federal emissions guidelines), or federal regulations as set forth in 40 CFR Parts 60, 61 and 63 but not yet adopted by the state. If the department determines that technological or economic limitations on the application of measurement methodology to a particular emissions unit would make the imposition of an emissions standard infeasible, a design, equipment, work practice, operational standard or combination thereof may be prescribed instead to satisfy the requirement for the application of best available control technology. Such standard shall, to the degree possible, set forth the emissions reduction achievable by implementation of such design, equipment, work practice or operation and shall provide for compliance by means which achieve equivalent results.

“*Building, structure, facility, or installation*” means all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same major group (i.e., which have the same two-digit code) as described in the Standard Industrial Classification Manual, 1972, as amended by the 1977 Supplement (U.S. Government Printing Office stock numbers 4101-0066 and 003-005-00176-0, respectively).

“CFR” means the Code of Federal Regulations, with standard references in this chapter by title and part, so that “40 CFR 51” or “40 CFR Part 51” means “Title 40 Code of Federal Regulations, Part 51.”

“Clean coal technology” means any technology, including technologies applied at the precombustion, combustion, or postcombustion stage, at a new or existing facility which will achieve significant reductions in air emissions of sulfur dioxide or oxides of nitrogen associated with the utilization of coal in the generation of electricity, or process steam which was not in widespread use as of November 15, 1990.

“Clean coal technology demonstration project” means a project using funds appropriated under the heading “Department of Energy—Clean Coal Technology,” up to a total amount of \$2,500,000,000 for commercial demonstration of clean coal technology, or similar projects funded through appropriations for the Environmental Protection Agency. The federal contribution for a qualifying project shall be at least 20 percent of the total cost of the demonstration project.

“Commence,” as applied to construction of a major stationary source or major modification, means that the owner or operator has all necessary preconstruction approvals or permits and either has:

1. Begun, or caused to begin, a continuous program of actual on-site construction of the source, to be completed within a reasonable time; or

2. Entered into binding agreements or contractual obligations, which cannot be canceled or modified without substantial loss to the owner or operator, to undertake a program of actual construction of the source to be completed within a reasonable time.

“Complete” means, in reference to an application for a permit, that the application contains all the information necessary for processing the application. Designating an application complete for purposes of permit processing does not preclude the department from requesting or accepting any additional information.

“Construction” means any physical change or change in the method of operation, including fabrication, erection, installation, demolition, or modification of an emissions unit, that would result in a change in emissions.

“Continuous emissions monitoring system” or “CEMS” means all of the equipment that may be required to meet the data acquisition and availability requirements of this chapter, to sample, to condition (if applicable), to analyze, and to provide a record of emissions on a continuous basis.

“Continuous emissions rate monitoring system” or “CERMS” means the total equipment required for the determination and recording of the pollutant mass emissions rate (in terms of mass per unit of time).

“Continuous parameter monitoring system” or “CPMS” means all of the equipment necessary to meet the data acquisition and availability requirements of this chapter, to monitor the process device operational parameters and the control device operational parameters (e.g., control device secondary voltages and electric currents) and other information (e.g., gas flow rate, O<sub>2</sub> or CO<sub>2</sub> concentrations), and to record the average operational parameter value(s) on a continuous basis.

“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 electrical output to any utility power distribution system for sale. 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 also considered in determining the electrical energy output capacity of the affected facility.

“Emissions unit” means any part of a stationary source that emits or would have the potential to emit any regulated NSR pollutant and includes an electric utility steam generating unit. For purposes of this chapter, there are two types of emissions units:

1. A new emissions unit is any emissions unit that is (or will be) newly constructed and that has existed for less than two years from the date such emissions unit first operated.

2. An existing emissions unit is any emissions unit that does not meet the requirements in “1” above. A replacement unit is an existing emissions unit.

“Enforceable permit condition,” for the purpose of this chapter, means any of the following limitations and conditions: requirements developed pursuant to new source performance standards,

prevention of significant deterioration standards, emissions standards for hazardous air pollutants, requirements within the SIP, and any permit requirements established pursuant to this chapter, any permit requirements established pursuant to 40 CFR 52.21 or Part 51, Subpart I, as amended through October 20, 2010, or under construction or Title V operating permit rules.

*"Federal land manager"* means, with respect to any lands in the United States, the secretary of the department with authority over such lands.

*"Federally enforceable"* means all limitations and conditions which are enforceable by the Administrator and the department, including those federal requirements not yet adopted by the state, developed pursuant to 40 CFR Parts 60, 61 and 63; requirements within 567—subrules 23.1(2) through 23.1(5); requirements within the SIP; any permit requirements established pursuant to 40 CFR 52.21 or under regulations approved pursuant to 40 CFR Part 51, Subpart I, as amended through October 20, 2010, including operating permits issued under an EPA-approved program, that are incorporated into the SIP and expressly require adherence to any permit issued under such program.

*"Fugitive emissions"* means those emissions which could not reasonably pass through a stack, chimney, vent, or other functionally equivalent opening.

*"High terrain"* means any area having an elevation 900 feet or more above the base of the stack of a source.

*"Indian governing body"* means the governing body of any tribe, band, or group of Indians subject to the jurisdiction of the United States and recognized by the United States as possessing power of self-government.

*"Indian reservation"* means any federally recognized reservation established by treaty, agreement, executive order, or Act of Congress.

*"Innovative control technology"* means any system of air pollution control that has not been adequately demonstrated in practice, but would have a substantial likelihood of achieving greater continuous emissions reduction than any control system in current practice or of achieving at least comparable reductions at lower cost in terms of energy, economics, or non-air quality environmental impacts.

*"Lowest achievable emissions rate"* or *"LAER"* means, for any source, the more stringent rate of emissions based on the following:

1. The most stringent emissions limitation which is contained in the SIP for such class or category of stationary source, unless the owner or operator of the proposed stationary source demonstrates that such limitations are not achievable; or

2. The most stringent emissions limitation which is achieved in practice by such class or category of stationary sources. This limitation, when applied to a modification, means the lowest achievable emissions rate for the new or modified emissions units within a stationary source. In no event shall the application of the term permit a proposed new or modified stationary source to emit any pollutant in excess of the amount allowable under an applicable new source standard of performance.

*"Low terrain"* means any area other than high terrain.

*"Major modification"* means any physical change in or change in the method of operation of a major stationary source that would result in a significant emissions increase of a regulated NSR pollutant and a significant net emissions increase of that pollutant from the major stationary source.

1. Any significant emissions increase from any emissions units or net emissions increase at a major stationary source that is significant for volatile organic compounds or NO<sub>x</sub> shall be considered significant for ozone.

2. A physical change or change in the method of operation shall not include:

- (a) Routine maintenance, repair and replacement
- (b) Use of an alternative fuel or raw material by reason of any order under Section 2(a) and (b) of the Energy Supply and Environmental Coordination Act of 1974 or by reason of a natural gas curtailment plan pursuant to the Federal Power Act;
- (c) Use of an alternative fuel by reason of an order or rule under Section 125 of the Act;
- (d) Use of an alternative fuel at a steam generating unit to the extent that the fuel is generated from municipal solid waste;

(e) Use of an alternative fuel or raw material by a stationary source that the source was capable of accommodating before January 6, 1975, unless such change would be prohibited under any federally enforceable permit condition, or that the source is approved to use under any federally enforceable permit condition;

(f) An increase in the hours of operation or in the production rate, unless such change would be prohibited under any federally enforceable permit condition which was established after January 6, 1975;

(g) Any change in ownership at a stationary source;

(h) Reserved.

(i) The installation, operation, cessation, or removal of a temporary clean coal technology demonstration project, provided that the project complies with the requirements within the SIP; and other requirements necessary to attain and maintain the national ambient air quality standards during the project and after the project is terminated;

(j) The installation or operation of a permanent clean coal technology demonstration project that constitutes repowering, provided that the project does not result in an increase in the potential to emit of any regulated pollutant emitted by the unit. This exemption shall apply on a pollutant-by-pollutant basis;

(k) The reactivation of a very clean coal-fired electric utility steam generating unit.

3. This definition shall not apply with respect to a particular regulated NSR pollutant when the major stationary source is complying with the requirements under rule 567—33.9(455B) for a PAL for that pollutant. Instead, the definition under rule 567—33.9(455B) shall apply.

*“Major source baseline date”* is defined under the definition of “baseline date.”

*“Major stationary source”* means:

(1) (a) Any one of the following stationary sources of air pollutants which emits, or has the potential to emit, 100 tons per year or more of any regulated NSR pollutant:

- Fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input;

- Coal cleaning plants (with thermal dryers);
- Kraft pulp mills;
- Portland cement plants;
- Primary zinc smelters;
- Iron and steel mill plants;
- Primary aluminum ore reduction plants;
- Primary copper smelters;
- Municipal incinerators capable of charging more than 250 tons of refuse per day;
- Hydrofluoric, sulfuric, and nitric acid plants;
- Petroleum refineries;
- Lime plants;
- Phosphate rock processing plants;
- Coke oven batteries;
- Sulfur recovery plants;
- Carbon black plants (furnace process);
- Primary lead smelters;
- Fuel conversion plants;
- Sintering plants;
- Secondary metal production plants;
- Chemical process plants (which does not include ethanol production facilities that produce ethanol by natural fermentation included in NAICS code 325193 or 312140);

- Fossil-fuel boilers (or combinations thereof) totaling more than 250 million British thermal units per hour heat input;

- Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels;
- Taconite ore processing plants;
- Glass fiber processing plants; and
- Charcoal production plants.

(b) Notwithstanding the stationary source size specified in paragraph “1”(a), any stationary source which emits, or has the potential to emit, 250 tons per year or more of a regulated NSR pollutant; or

(c) Any physical change that would occur at a stationary source not otherwise qualifying under this definition as a major stationary source if the change would constitute a major stationary source by itself.

(2) A major source that is major for volatile organic compounds or NO<sub>x</sub> shall be considered major for ozone.

(3) The fugitive emissions of a stationary source shall not be included in determining for any of the purposes of this rule whether it is a major stationary source, unless the source belongs to one of the categories of stationary sources listed in paragraph “1”(a) of this definition or to any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the Act.

“*Minor source baseline date*” is defined under the definition of “baseline date.”

“*Necessary preconstruction approvals or permits*” means those permits or approvals required under federal air quality control laws and regulations and those air quality control laws and regulations which are part of the SIP.

“*Net emissions increase*” means, with respect to any regulated NSR pollutant emitted by a major stationary source, the amount by which the following exceeds zero:

- The increase in emissions from a particular physical change or change in the method of operation at a stationary source as calculated according to the applicability requirements under subrule 33.3(2); and

- Any other increases and decreases in actual emissions at the major stationary source that are contemporaneous with the particular change and are otherwise creditable. Baseline actual emissions for calculating increases and decreases under this definition of “net emissions increase” shall be determined as provided for under the definition of “baseline actual emissions,” except that paragraphs “1”(c) and “2”(d) of the definition of “baseline actual emissions,” which describe provisions for multiple emissions units, shall not apply.

1. An increase or decrease in actual emissions is contemporaneous with the increase from the particular change only if the increase or decrease in actual emissions occurs between the date five years before construction on the particular change commences and the date that the increase from the particular change occurs.

2. An increase or decrease in actual emissions is creditable only if:

- (a) The increase or decrease in actual emissions occurs within the contemporaneous time period, as noted in paragraph “1” of this definition; and

- (b) The department has not relied on the increase or decrease in actual emissions in issuing a permit for the source under this rule, which permit is in effect when the increase in actual emissions from the particular change occurs.

3. An increase or decrease in actual emissions of sulfur dioxide, particulate matter, or nitrogen oxides that occurs before the applicable minor source baseline date is creditable only if the increase or decrease in actual emissions is required to be considered in calculating the amount of maximum allowable increases remaining available.

4. An increase in actual emissions is creditable only to the extent that the new level of actual emissions exceeds the old level.

5. A decrease in actual emissions is creditable only to the extent that:

- (a) The old level of actual emissions or the old level of allowable emissions, whichever is lower, exceeds the new level of actual emissions;

- (b) The decrease in actual emissions is enforceable as a practical matter at and after the time that actual construction on the particular change begins; and

- (c) The decrease in actual emissions has approximately the same qualitative significance for public health and welfare as that attributed to the increase from the particular change.

6. An increase that results from a physical change at a source occurs when the emissions unit on which construction occurred becomes operational and begins to emit a particular pollutant. Any replacement unit that requires shakedown becomes operational only after a reasonable shakedown period, not to exceed 180 days.

7. The definition of “actual emissions,” paragraph “2,” shall not apply for determining creditable increases and decreases.

“*Nonattainment area*” means an area so designated by the Administrator, acting pursuant to Section 107 of the Act.

“*Permitting authority*” means the Iowa department of natural resources or the director thereof.

“*Pollution prevention*” means any activity that, through process changes, product reformulation or redesign, or substitution of less polluting raw materials, eliminates or reduces the release of air pollutants (including fugitive emissions) and other pollutants to the environment prior to recycling, treatment, or disposal. “Pollution prevention” does not mean recycling (other than certain “in-process recycling” practices), energy recovery, treatment, or disposal.

“*Potential to emit*” means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation or the effect it would have on emissions is federally enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

“*Predictive emissions monitoring system*” or “*PEMS*” means all of the equipment necessary to monitor the process device operational parameters and the control device operational parameters (e.g., control device secondary voltages and electric currents) and other information (e.g., gas flow rate, O<sub>2</sub> or CO<sub>2</sub> concentrations), and calculate and record the mass emissions rate (e.g., lb/hr) on a continuous basis.

“*Prevention of significant deterioration (PSD) program*” means a major source preconstruction permit program that has been approved by the Administrator and incorporated into the SIP or means the program in 40 CFR 52.21. Any permit issued under such a program is a major NSR permit.

“*Project*” means a physical change in, or change in method of operation of, an existing major stationary source.

“*Projected actual emissions,*” for the purposes of this chapter, means the maximum annual rate, in tons per year, at which an existing emissions unit is projected to emit a regulated NSR pollutant in any one of the five years (12-month period) beginning on the first day of the month following the date when the unit resumes regular operation after the project, or in any one of the ten years following that date, if the project involves increasing the emissions unit’s design capacity or its potential to emit that regulated NSR pollutant, and full utilization of the unit would result in a significant emissions increase, or a significant net emissions increase at the major stationary source. For purposes of this definition, “regular” shall be determined by the department on a case-by-case basis.

In determining the projected actual emissions before beginning actual construction, the owner or operator of the major stationary source:

1. Shall consider all relevant information including, but not limited to, historical operational data, the company’s own representations, the company’s expected business activity and the company’s highest projections of business activity, the company’s filings with the state or federal regulatory authorities, and compliance plans under the approved plan; and

2. Shall include fugitive emissions to the extent quantifiable and emissions associated with startups, shutdowns, and malfunctions; and

3. Shall exclude, in calculating any increase in emissions that results from the particular project, that portion of the unit’s emissions following the project that an existing unit could have accommodated during the consecutive 24-month period used to establish the baseline actual emissions and that are also unrelated to the particular project, including any increased utilization due to product demand growth; and

4. In lieu of using the method set out in paragraphs “1” through “3,” may elect to use the emissions unit’s potential to emit, in tons per year.

“*Reactivation of a very clean coal-fired electric utility steam generating unit*” means any physical change or change in the method of operation associated with the commencement of commercial operations by a coal-fired utility unit after a period of discontinued operation in which the unit:

1. Has not been in operation for the two-year period prior to the enactment of the Act, and the emissions from such unit continue to be carried in the permitting authority's emissions inventory at the time of the enactment;

2. Was equipped prior to shutdown with a continuous system of emissions control that achieves a removal efficiency for sulfur dioxide of no less than 85 percent and a removal efficiency for particulates of no less than 98 percent;

3. Is equipped with low-NO<sub>x</sub> burners prior to the time of commencement of operations following reactivation; and

4. Is otherwise in compliance with the requirements of the Act.

*"Regulated NSR pollutant"* means the following:

1. Any pollutant for which a national ambient air quality standard has been promulgated and any constituents or precursors for such pollutants identified by the Administrator:

(a) Volatile organic compounds and nitrogen oxides are precursors to ozone in all attainment and unclassifiable areas;

(b) Sulfur dioxide is a precursor to PM<sub>2.5</sub> in all attainment and unclassifiable areas;

(c) Nitrogen oxides are presumed to be precursors to PM<sub>2.5</sub> in all attainment and unclassifiable areas, unless the department demonstrates to EPA's satisfaction or EPA demonstrates that emissions of nitrogen oxides from sources in a specific area are not a significant contributor to the area's ambient PM<sub>2.5</sub> concentrations;

(d) Volatile organic compounds are presumed not to be precursors to PM<sub>2.5</sub> in any attainment and unclassifiable areas, unless the department demonstrates to EPA's satisfaction or EPA demonstrates that emissions of volatile organic compounds from sources in a specific area are a significant contributor to that area's ambient PM<sub>2.5</sub> concentrations;

2. Any pollutant that is subject to any standard promulgated under Section 111 of the Act;

3. Any Class I or Class II substance subject to a standard promulgated under or established by Title VI of the Act; or

4. Any pollutant that otherwise is subject to regulation under the Act as defined in 33.3(1), definition of "subject to regulation."

5. Notwithstanding paragraphs "1" through "4," the definition of "regulated NSR pollutant" shall not include any or all hazardous air pollutants that are either listed in Section 112 of the Act or added to the list pursuant to Section 112(b)(2) of the Act and that have not been delisted pursuant to Section 112(b)(3) of the Act, unless the listed hazardous air pollutant is also regulated as a constituent or precursor of a general pollutant listed under Section 108 of the Act.

6. Particulate matter (PM) emissions, PM<sub>2.5</sub> emissions and PM<sub>10</sub> emissions shall include gaseous emissions from a source or activity which condense to form particulate matter at ambient temperatures.

*"Replacement unit"* means an emissions unit for which all the criteria listed in paragraphs "1" through "4" of this definition are met. No creditable emissions reductions shall be generated from shutting down the existing emissions unit that is replaced.

1. The emissions unit is a reconstructed unit within the meaning of 40 CFR 60.15(b)(1) as amended through December 16, 1975, or the emissions unit completely takes the place of an existing emissions unit.

2. The emissions unit is identical to or functionally equivalent to the replaced emissions unit.

3. The replacement does not change the basic design parameter(s) of the process unit.

4. The replaced emissions unit is permanently removed from the major stationary source, otherwise permanently disabled, or permanently barred from operation by a permit that is enforceable as a practical matter. If the replaced emissions unit is brought back into operation, it shall constitute a new emissions unit.

*"Repowering"* means:

1. Replacement of an existing coal-fired boiler with one of the following clean coal technologies: atmospheric or pressurized fluidized bed combustion; integrated gasification combined cycle; magnetohydrodynamics; direct and indirect coal-fired turbines; integrated gasification fuel cells; or, as determined by the Administrator in consultation with the Secretary of Energy, a derivative of one

or more of these technologies; and any other technology capable of controlling multiple combustion emissions simultaneously with improved boiler or generation efficiency and with significantly greater waste reduction relative to the performance of technology in widespread commercial use as of November 15, 1990.

2. Repowering shall also include any oil or gas-fired unit which has been awarded clean coal technology demonstration funding as of January 1, 1991, by the Department of Energy.

3. The department shall give expedited consideration to permit applications for any source that satisfies the requirements of this definition and is granted an extension under Section 409 of the Act.

“*Reviewing authority*” means the department, or the Administrator in the case of EPA-implemented permit programs under 40 CFR 52.21.

“*Secondary emissions*” means emissions which occur as a result of the construction or operation of a major stationary source or major modification, but do not come from the major stationary source or major modification itself. For the purposes of this chapter, “secondary emissions” must be specific, well-defined, and quantifiable, and must impact the same general areas as the stationary source modification which causes the secondary emissions. “Secondary emissions” includes emissions from any offsite support facility which would not be constructed or increase its emissions except as a result of the construction or operation of the major stationary source or major modification. “Secondary emissions” does not include any emissions which come directly from a mobile source, such as emissions from the tailpipe of a motor vehicle, from a train, or from a vessel.

“*Significant*” means:

1. In reference to a net emissions increase or the potential of a source to emit any of the following pollutants, a rate of emissions that would equal or exceed any of the following rates:

Pollutant and Emissions Rate

- Carbon monoxide: 100 tons per year (tpy)
- Nitrogen oxides: 40 tpy
- Sulfur dioxide: 40 tpy
- Particulate matter: 25 tpy of particulate matter emissions
- PM<sub>10</sub>: 15 tpy
- PM<sub>2.5</sub>: 10 tpy of direct PM<sub>2.5</sub> emissions; 40 tpy of sulfur dioxide emissions; 40 tpy of nitrogen oxide emissions (unless the department demonstrates to EPA’s satisfaction that emissions of nitrogen oxides from sources in a specific area are not a significant contributor to the area’s ambient PM<sub>2.5</sub> concentrations)
  - Ozone: 40 tpy of volatile organic compounds or NO<sub>x</sub>
  - Lead: 0.6 tpy
  - Fluorides: 3 tpy
  - Sulfuric acid mist: 7 tpy
  - Hydrogen sulfide (H<sub>2</sub>S): 10 tpy
  - Total reduced sulfur (including H<sub>2</sub>S): 10 tpy
  - Reduced sulfur compounds (including H<sub>2</sub>S): 10 tpy
  - Municipal waste combustor organics (measured as total tetra- through octa-chlorinated dibenzo-p-dioxins and dibenzofurans):  $3.2 \times 10^{-6}$  megagrams per year ( $3.5 \times 10^{-6}$  tons per year)
  - Municipal waste combustor metals (measured as particulate matter): 14 megagrams per year (15 tons per year)
  - Municipal waste combustor acid gases (measured as sulfur dioxide and hydrogen chloride): 36 megagrams per year (40 tons per year)
  - Municipal solid waste landfill emissions (measured as nonmethane organic compounds): 45 megagrams per year (50 tons per year)

2. “Significant” means, for purposes of this rule and in reference to a net emissions increase or the potential of a source to emit a regulated NSR pollutant not listed in paragraph “1,” any emissions rate.

3. Notwithstanding paragraph “1,” “significant,” for purposes of this rule, means any emissions rate or any net emissions increase associated with a major stationary source or major modification, which

would construct within ten kilometers of a Class I area and have an impact on such area equal to or greater than 1  $\mu\text{g}/\text{m}^3$  (24-hour average).

“*Significant emissions increase*” means, for a regulated NSR pollutant, an increase in emissions that is significant for that pollutant.

“*State implementation plan*” or “*SIP*” means the plan adopted by the state of Iowa and approved by the Administrator which provides for implementation, maintenance, and enforcement of such primary and secondary ambient air quality standards as they are adopted by the Administrator, pursuant to the Act.

“*Stationary source*” means any building, structure, facility, or installation which emits or may emit a regulated NSR pollutant.

“*Subject to regulation*” means, for any air pollutant, that the pollutant is subject to either a provision in the Clean Air Act, or a nationally applicable regulation codified by the Administrator in 40 CFR Subchapter C (Air Programs) that requires actual control of the quantity of emissions of that pollutant, and that such a control requirement has taken effect and is operative to control, limit or restrict the quantity of emissions of that pollutant released from the regulated activity, except that:

1. Greenhouse gases (GHGs), the air pollutant defined in 40 CFR §86.1818-12(a) (as amended through September 15, 2011) as the aggregate group of six greenhouse gases that includes carbon dioxide, nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride, shall not be subject to regulation except as provided in paragraphs “4” and “5,” and shall not be subject to regulation if the stationary source maintains its total sourcewide emissions below the GHG PAL level, meets the requirements in rule 567—33.9(455B), and complies with the PAL permit containing the GHG PAL.

2. For purposes of paragraphs “3,” “4,” and “5,” the term “tpy CO<sub>2</sub> equivalent emissions (CO<sub>2</sub>e)” shall represent an amount of GHGs emitted and shall be computed as follows:

(a) Multiply the mass amount of emissions (tpy) for each of the six greenhouse gases in the pollutant GHGs by the associated global warming potential of the gas published at 40 CFR Part 98, Subpart A, Table A-1, “Global Warming Potentials,” (as amended on October 30, 2009). For purposes of this definition, prior to July 21, 2014, the mass of the greenhouse gas carbon dioxide shall not include carbon dioxide emissions resulting from the combustion or decomposition of non-fossilized and biodegradable organic material originating from plants, animals, or micro-organisms (including products, by-products, residues and waste from agriculture, forestry and related industries as well as the non-fossilized and biodegradable organic fractions of industrial and municipal wastes, including gases and liquids recovered from the decomposition of non-fossilized and biodegradable organic material).

(b) Sum the resultant value from paragraph (a) for each gas to compute a tpy CO<sub>2</sub>e.

3. The term “emissions increase,” as used in this paragraph and in paragraphs “4” and “5,” shall mean that both a significant emissions increase (as calculated using the procedures specified in 33.3(2) “c” through 33.3(2) “h”) and a significant net emissions increase (as specified in 33.3(1), in the definitions of “net emissions increase” and “significant”) occur. For the pollutant GHGs, an emissions increase shall be based on tpy CO<sub>2</sub>e and shall be calculated assuming the pollutant GHGs are a regulated NSR pollutant, and “significant” is defined as 75,000 tpy CO<sub>2</sub>e rather than calculated by applying the value specified in 33.3(1), in paragraph “2” of the definition of “significant.”

4. Beginning January 2, 2011, the pollutant GHGs are subject to regulation if:

(a) The stationary source is a new major stationary source for a regulated NSR pollutant that is not a GHG, and also will emit or will have the potential to emit 75,000 tpy CO<sub>2</sub>e or more, or

(b) The stationary source is an existing major stationary source for a regulated NSR pollutant that is not a GHG, and also will have an emissions increase of a regulated NSR pollutant and an emissions increase of 75,000 tpy CO<sub>2</sub>e or more; and

5. Beginning July 1, 2011, in addition to the provisions in paragraph “4,” the pollutant GHGs shall also be subject to regulation:

(a) At a new stationary source that will emit or have the potential to emit 100,000 tpy CO<sub>2</sub>e, or

(b) At an existing stationary source that emits or has the potential to emit 100,000 tpy CO<sub>2</sub>e, when such stationary source undertakes a physical change or change in the method of operation that will result in an emissions increase of 75,000 tpy CO<sub>2</sub>e or more.

*“Temporary clean coal technology demonstration project”* means a clean coal technology demonstration project that is operated for a period of five years or less and that complies with the SIP and other requirements necessary to attain and maintain the national ambient air quality standards during the project and after the project is terminated.

*“Title V permit”* means an operating permit under Title V of the Act.

*“Volatile organic compounds”* or *“VOC”* means any compound included in the definition of “volatile organic compounds” found at 40 CFR 51.100(s) as amended through March 27, 2014.

**33.3(2) Applicability.** The requirements of this rule (PSD program requirements) apply to the construction of any new “major stationary source” as defined in subrule 33.3(1) or any project at an existing major stationary source in an area designated as attainment or unclassifiable under Section 107(d)(1)(A)(ii) or (iii) of the Act. In addition to the provisions set forth in rules 567—33.3(455B) through 567—33.9(455B), the provisions of 40 CFR Part 51, Appendix W (Guideline on Air Quality Models) as amended through November 9, 2005, are adopted by reference.

a. The requirements of subrules 33.3(10) through 33.3(18) apply to the construction of any new major stationary source or the major modification of any existing major stationary source, except as this rule (PSD program requirements) otherwise provides.

b. No new major stationary source or major modification to which the requirements of subrule 33.3(10) through paragraph 33.3(18) “e” apply shall begin actual construction without a permit that states that the major stationary source or major modification will meet those requirements.

c. Except as otherwise provided in paragraphs 33.3(2) “i” and “j,” and consistent with the definition of “major modification” contained in subrule 33.3(1), a project is a major modification for a “regulated NSR pollutant” if it causes two types of emissions increases: a “significant emissions increase”; and a “net emissions increase” which is “significant.” The project is not a major modification if it does not cause a significant emissions increase. If the project causes a significant emissions increase, then the project is a major modification only if it also results in a significant net emissions increase.

d. The procedure for calculating (before beginning actual construction) whether a significant emissions increase (i.e., the first step of the process) will occur depends upon the type of emissions units being modified, according to paragraphs “e” through “h” of this subrule. The procedure for calculating (before beginning actual construction) whether a significant net emissions increase will occur at the major stationary source (i.e., the second step of the process) is contained in the definition of “net emissions increase.” Regardless of any such preconstruction projections, a major modification results if the project causes a significant emissions increase and a significant net emissions increase.

e. Actual-to-projected-actual applicability test for projects that only involve existing emissions units. A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the difference between the “projected actual emissions” and the “baseline actual emissions” for each existing emissions unit equals or exceeds the significant amount for that pollutant.

f. Actual-to-potential test for projects that involve only construction of a new emissions unit(s). A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the difference between the “potential to emit” from each new emissions unit following completion of the project and the “baseline actual emissions” for a new emissions unit before the project equals or exceeds the significant amount for that pollutant.

g. Reserved.

h. Hybrid test for projects that involve multiple types of emissions units. A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the emissions increases for each emissions unit, using the method specified in paragraphs “e” through “g” of this subrule, as applicable with respect to each emissions unit, for each type of emissions unit equals or exceeds the significant amount for that pollutant.

i. For any major stationary source with a PAL for a regulated NSR pollutant, the major stationary source shall comply with rule requirements under 567—33.9(455B).

*j.* Reserved.

**33.3(3) *Ambient air increments.*** The provisions for ambient air increments as specified in 40 CFR 52.21(c) as amended through October 20, 2010, are adopted by reference.

**33.3(4) *Ambient air ceilings.*** The provisions for ambient air ceilings as specified in 40 CFR 52.21(d) as amended through November 29, 2005, are adopted by reference.

**33.3(5) *Restrictions on area classifications.*** The provisions for restrictions on area classifications as specified in 40 CFR 52.21(e) as amended through November 29, 2005, are adopted by reference.

**33.3(6) *Exclusions from increment consumption.*** The provisions by which the SIP may provide for exclusions from increment consumption as specified in 40 CFR 51.166(f) as amended through November 29, 2005, are adopted by reference. The following phrases contained in 40 CFR 51.166(f) are not adopted by reference: “the plan may provide that,” “the plan provides that,” and “it shall also provide that.” Additionally, the term “the plan” shall mean “SIP.”

**33.3(7) *Redesignation.*** The provisions for redesignation as specified in 40 CFR 52.21(g) as amended through November 29, 2005, are adopted by reference.

**33.3(8) *Stack heights.*** The provisions for stack heights as specified in 40 CFR 52.21(h) as amended through November 29, 2005, are adopted by reference.

**33.3(9) *Exemptions.*** The provisions for allowing exemptions from certain requirements for PSD-subject sources as specified in 40 CFR 52.21(i) as amended through October 20, 2010, are adopted by reference.

**33.3(10) *Control technology review.*** The provisions for control technology review as specified in 40 CFR 52.21(j) as amended through November 29, 2005, are adopted by reference.

**33.3(11) *Source impact analysis.*** The provisions for a source impact analysis as specified in 40 CFR 52.21(k) as amended through October 20, 2010, are adopted by reference.

**33.3(12) *Air quality models.*** The provisions for air quality models as specified in 40 CFR 52.21(l) as amended through November 29, 2005, are adopted by reference.

**33.3(13) *Air quality analysis.*** The provisions for an air quality analysis as specified in 40 CFR 52.21(m) as amended through November 29, 2005, are adopted by reference.

**33.3(14) *Source information.*** The provisions for providing source information as specified in 40 CFR 52.21(n) as amended through November 29, 2005, are adopted by reference.

**33.3(15) *Additional impact analyses.*** The provisions for an additional impact analysis as specified in 40 CFR 52.21(o) as amended through November 29, 2005, are adopted by reference.

**33.3(16) *Sources impacting federal Class I areas—additional requirements.*** The provisions for sources impacting federal Class I areas as specified in 40 CFR 51.166(p) as amended through October 20, 2010, are adopted by reference. The following phrases contained in 40 CFR 51.166(p) are not adopted by reference: “the plan may provide that,” “the plan shall provide that,” “the plan shall provide” and “mechanism whereby.”

**33.3(17) *Public participation.***

*a.* The department shall notify all applicants within 30 days as to the completeness of the application or any deficiency in the application or information submitted. In the event of such a deficiency, the date of receipt of the application shall be the date on which the department received all required information.

*b.* Within one year after receipt of a complete application, the department shall:

(1) Make a preliminary determination whether construction should be approved, approved with conditions, or disapproved.

(2) Make available in at least one location in each region in which the proposed source would be constructed a copy of all materials the applicant submitted, a copy of the preliminary determination, and a copy or summary of other materials, if any, considered in making the preliminary determination.

(3) Notify the public, by advertisement in a newspaper of general circulation in each region in which the proposed source would be constructed, of the application, of the preliminary determination, of the degree of increment consumption that is expected from the source or modification, and of the opportunity for comment at a public hearing as well as written public comment. At least 30 days shall be provided for public comment and for notification of any public hearing.

(4) Send a copy of the notice of public comment to the applicant, to the Administrator and to officials and agencies having cognizance over the location where the proposed construction would occur as follows: any other state or local air pollution control agencies; the chief executives of the city and county where the source would be located; any comprehensive regional land use planning agency; and any state, federal land manager, or Indian governing body whose lands may be affected by emissions from the source or modification.

(5) Provide opportunity for a public hearing for interested persons to appear and submit written or oral comments on the air quality impact of the source, alternatives to the proposed source or modification, the control technology required, and other appropriate considerations. At least 30 days' notice shall be provided for any public hearing.

(6) Consider all written comments submitted within a time specified in the notice of public comment and all comments received at any public hearing(s) in making a final decision on the approvability of the application. The department shall make all comments available for public inspection at the same locations where the department made available preconstruction information relating to the proposed source or modification.

(7) Make a final determination whether construction should be approved, approved with conditions, or disapproved.

(8) Notify the applicant in writing of the final determination and make such notification available for public inspection at the same locations where the department made available preconstruction information and public comments relating to the proposed source or modification.

*c. Reopening of the public comment period.*

(1) If comments submitted during the public comment period raise substantial new issues concerning the permit, the department may, at its discretion, take one or more of the following actions:

1. Prepare a new draft permit, appropriately modified;
2. Prepare a revised fact sheet;
3. Prepare a revised fact sheet and reopen the public comment period; or
4. Reopen or extend the public comment period to provide interested persons an opportunity to comment on the comments submitted.

(2) The public notice provided by the department pursuant to this rule shall define the scope of the reopening. Department review of any comments filed during a reopened comment period shall be limited to comments pertaining to the substantial new issues causing the reopening.

**33.3(18) Source obligation.**

*a.* Approval to construct shall not relieve any owner or operator of the responsibility to comply fully with applicable provisions of the plan and any other requirements under local, state or federal law.

*b.* At such time that a particular source or modification becomes a major stationary source or major modification solely by virtue of a relaxation in any enforceable limitation which was established after August 7, 1980, on the capacity of the source or modification otherwise to emit a pollutant, such as a restriction on hours of operation, the requirements of subrules 33.3(10) through 33.3(19) shall apply to the source or modification as though construction had not yet commenced on the source or modification.

*c.* Any owner or operator who constructs or operates a source or modification not in accordance with the application pursuant to the provisions in rule 567—33.3(455B) or with the terms of any approval to construct, or any owner or operator of a source or modification subject to the provisions in rule 567—33.3(455B) who commences construction after April 15, 1987 (the effective date of Iowa's PSD program), without applying for and receiving department approval, shall be subject to appropriate enforcement action.

*d.* Approval to construct shall become invalid if construction is not commenced within 18 months after receipt of such approval, if construction is discontinued for a period of 18 months or more, or if construction is not completed within a reasonable time. The department may extend the 18-month period upon a satisfactory showing that an extension is justified. These provisions do not apply to the time between construction of the approved phases of a phased construction project; each phase must commence construction within 18 months of the projected and approved commencement date.

*e.* Reserved.

*f.* Except as otherwise provided in subparagraph (8), the following specific provisions shall apply with respect to any regulated NSR pollutant emitted from projects at existing emissions units at a major stationary source, other than projects at a source with a PAL, in circumstances where there is a “reasonable possibility,” within the meaning of subparagraph (8), that a project that is not part of a major modification may result in a significant emissions increase of such pollutant, and the owner or operator elects to use the method for calculating projected actual emissions as specified in subrule 33.3(1), paragraphs “1” through “3” of the definition of “projected actual emissions.”

(1) Before beginning actual construction of the project, the owner or operator shall document and maintain a record of the following information:

1. A description of the project;
2. Identification of the emissions unit(s) whose emissions of a regulated NSR pollutant could be affected by the project; and
3. A description of the applicability test used to determine that the project is not a major modification for any regulated NSR pollutant, including the baseline actual emissions, the projected actual emissions, the amount of emissions excluded under paragraph “3” of the definition of “projected actual emissions” in subrule 33.3(1), an explanation describing why such amount was excluded, and any netting calculations, if applicable.

(2) No less than 30 days before beginning actual construction, the owner or operator shall meet with the department to discuss the owner’s or operator’s determination of projected actual emissions for the project and shall provide to the department a copy of the information specified in paragraph “*f.*” The owner or operator is not required to obtain a determination from the department regarding the project’s projected actual emissions prior to beginning actual construction.

(3) If the emissions unit is an existing electric utility steam generating unit, before beginning actual construction, the owner or operator shall provide a copy of the information set out in subparagraph (1) to the department. The requirements in subparagraphs (1), (2) and (3) shall not be construed to require the owner or operator of such a unit to obtain any determination from the department before beginning actual construction.

(4) The owner or operator shall:

1. Monitor the emissions of any regulated NSR pollutant that could increase as a result of the project and that is emitted by any emissions unit identified in subparagraph (1);

2. Calculate the annual emissions, in tons per year on a calendar-year basis, for a period of five years following resumption of regular operations and maintain a record of regular operations after the change, or for a period of ten years following resumption of regular operations after the change if the project increases the design capacity or potential to emit of that regulated NSR pollutant at such emissions unit (for purposes of this requirement, “regular” shall be determined by the department on a case-by-case basis); and

3. Maintain a written record containing the information required in this subparagraph.

(5) The written record containing the information required in subparagraph (4) shall be retained by the owner or operator for a period of ten years after the project is completed.

(6) If the unit is an existing electric utility steam generating unit, the owner or operator shall submit a report to the department within 60 days after the end of each year during which records must be generated under subparagraph (4) setting out the unit’s annual emissions during the calendar year that preceded submission of the report.

(7) If the unit is an existing unit other than an electric utility steam generating unit, the owner or operator shall submit a report to the department if the annual emissions, in tons per year, from the project identified in subparagraph (1), exceed the baseline actual emissions, as documented and maintained pursuant to subparagraph (4), by an amount that is “significant” as defined in subrule 33.3(1) for that regulated NSR pollutant, and if such emissions differ from the preconstruction projection as documented and maintained pursuant to subparagraph (4). Such report shall be submitted to the department within 60 days after the end of such year. The report shall contain the following:

1. The name, address and telephone number of the major stationary source;
2. The annual emissions as calculated pursuant to subparagraph (4); and

3. Any other information that the owner or operator wishes to include in the report (e.g., an explanation as to why the emissions differ from the preconstruction projection).

(8) A “reasonable possibility” under this paragraph (paragraph 33.3(18) “f”) occurs when the owner or operator calculates the project to result in either:

1. A projected actual emissions increase of at least 50 percent of the amount that is a “significant emissions increase,” as defined under subrule 33.3(1) (without reference to the amount that is a significant net emissions increase), for the regulated NSR pollutant; or

2. A projected actual emissions increase that, when added to the amount of emissions excluded under subrule 33.3(1), paragraph “3” of the definition of “projected actual emissions,” equals at least 50 percent of the amount that is a “significant emissions increase,” as defined under subrule 33.3(1) (without reference to the amount that is a significant net emissions increase), for the regulated NSR pollutant. For a project for which a reasonable possibility occurs only within the meaning of this numbered paragraph, and not also within the meaning of numbered paragraph “1” of this subparagraph (subparagraph (8)), then the provisions of subparagraphs (3) through (7) do not apply to the project.

g. The owner or operator of the source shall make the information required to be documented and maintained pursuant to paragraph “f” available for review upon request for inspection by the department or the general public pursuant to the requirements for Title V operating permits contained in 567—subrule 22.107(6).

**33.3(19) Innovative control technology.** The provisions for innovative control technology as specified in 40 CFR 51.166(s) as amended through November 29, 2005, are adopted by reference. The following phrases contained in 40 CFR 51.166(s) are not adopted by reference: “the plan may provide that” and “the plan shall provide that.”

**33.3(20) Conditions for permit issuance.** Except as explained below, a permit may not be issued to any new “major stationary source” or “major modification” as defined in subrule 33.3(1) that would locate in any area designated as attainment or unclassifiable for any national ambient air quality standard pursuant to Section 107 of the Act, when the source or modification would cause or contribute to a violation of any national ambient air quality standard. A major stationary source or major modification will be considered to cause or contribute to a violation of a national ambient air quality standard when such source or modification would, at a minimum, exceed the following significance levels at any locality that does not or would not meet the applicable national standard:

Significant Impact Levels (SILs)					
	Averaging Time				
	Annual	24 hrs.	8 hrs.	3 hrs.	1 hr.
Pollutant	( $\mu\text{g}/\text{m}^3$ )				
SO <sub>2</sub>	1.0	5	—	25	—
PM <sub>10</sub>	1.0	5	—	—	—
PM <sub>2.5</sub>	0.3	1.2	—	—	—
NO <sub>2</sub>	1.0	—	—	—	—
CO	—	—	500	—	2000

A permit may be granted to a major stationary source or major modification as identified above if the major stationary source or major modification reduces the impact of its emissions upon air quality by obtaining sufficient emissions reductions to compensate for its adverse ambient air impact where the major stationary source or major modification would otherwise contribute to a violation of any national ambient air quality standard. This subrule shall not apply to a major stationary source or major modification with respect to a particular pollutant if the owner or operator demonstrates that the source is located in an area designated under Section 107 of the Act as nonattainment for that pollutant.

**33.3(21) Administrative amendments.**

a. Upon request for an administrative amendment, the department may take final action on any such request and may incorporate the requested changes without providing notice to the public or to

affected states, provided that the department designates any such permit revisions as having been made pursuant to subrule 33.3(21).

*b.* An administrative amendment is a permit revision that does any of the following:

- (1) Corrects typographical errors;
- (2) Corrects word processing errors;
- (3) Identifies a change in name, address or telephone number of any person identified in the permit or provides a similar minor administrative change at the source; or
- (4) Allows for a change in ownership or operational control of a source where the department determines that no other change in the permit is necessary, provided that a written agreement that contains a specific date for transfer of permit responsibility, coverage, and liability between the current permittee and the new permittee has been submitted to the department.

**33.3(22) Permit rescission.** Any permit issued under 40 CFR 52.21 or this chapter or any permit issued under rule 567—22.4(455B) shall remain in effect unless and until it is rescinded. The department will consider requests for rescission that meet the conditions specified under paragraphs “a” and “b” of this subrule. If the department rescinds a permit or a condition in a permit issued under 40 CFR 52.21, this chapter, or rule 567—22.4(455B), the public shall be given adequate notice of the proposed rescission. Publication of an announcement of rescission in a newspaper of general circulation in the affected region 60 days prior to the proposed date for rescission shall be considered adequate notice.

*a.* The department may rescind a permit or a portion of a permit upon request from an owner or operator of a stationary source who holds a permit for a source or modification that was issued under 40 CFR 52.21 as in effect on July 30, 1987, or earlier, provided the application also meets the provisions in paragraph “b” of this subrule.

*b.* If the application for rescission meets the provisions in paragraph “a” of this subrule, the department may rescind a permit if the owner or operator shows that the PSD provisions under 40 CFR 52.21 would not apply to the source or modification.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 9224B, IAB 11/17/10, effective 12/22/10; ARC 9906B, IAB 12/14/11, effective 11/16/11; ARC 0260C, IAB 8/8/12, effective 9/12/12; ARC 0783C, IAB 6/12/13, effective 7/17/13; ARC 1913C, IAB 3/18/15, effective 4/22/15]

**567—33.4 to 33.8** Reserved.

**567—33.9(455B) Plantwide applicability limitations (PALs).** This rule provides an existing major source the option of establishing a plantwide applicability limitation (PAL) on emissions, provided the conditions in this rule are met. The provisions for a PAL as set forth in 40 CFR 52.21(aa) as amended through July 12, 2012, are adopted by reference, except that the term “Administrator” shall mean “the department of natural resources.”

[ARC 0783C, IAB 6/12/13, effective 7/17/13]

**567—33.10(455B) Exceptions to adoption by reference.** All references to Clean Units and Pollution Control Projects set forth in 40 CFR Sections 52.21 and 51.166 are not adopted by reference.

These rules are intended to implement Iowa Code chapter 455B.

[Filed 8/25/06, Notice 6/7/06—published 9/27/06, effective 11/1/06]

[Filed 2/8/07, Notice 12/6/06—published 2/28/07, effective 4/4/07]

[Filed emergency 10/4/07 after Notice 8/1/07—published 10/24/07, effective 10/4/07]

[Filed 4/18/08, Notice 1/2/08—published 5/7/08, effective 6/11/08]

[Filed 8/20/08, Notice 6/4/08—published 9/10/08, effective 10/15/08]

[Filed ARC 8215B (Notice ARC 7855B, IAB 6/17/09), IAB 10/7/09, effective 11/11/09]

[Filed ARC 9224B (Notice ARC 8999B, IAB 8/11/10), IAB 11/17/10, effective 12/22/10]

[Filed Emergency After Notice ARC 9906B (Notice ARC 9736B, IAB 9/7/11), IAB 12/14/11, effective 11/16/11]

[Filed ARC 0260C (Notice ARC 0097C, IAB 4/18/12), IAB 8/8/12, effective 9/12/12]

[Filed ARC 0783C (Notice ARC 0648C, IAB 3/20/13), IAB 6/12/13, effective 7/17/13]

[Filed ARC 1227C (Notice ARC 1016C, IAB 9/18/13), IAB 12/11/13, effective 1/15/14]

[Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]  
[Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective  
12/16/15]



## **MEDICINE BOARD[653]**

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]  
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

### CHAPTER 1

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**653—9.1(147,148) Definitions.**

“*ABMS*” means the American Board of Medical Specialties, which is an umbrella organization for at least 24 medical specialty boards in the United States that assists the specialty boards in developing and implementing educational and professional standards to evaluate and certify physician specialists in the United States. The board recognizes specialty board certification by ABMS.

“*ACGME*” means the Accreditation Council for Graduate Medical Education, an accreditation body that is responsible for accreditation of post-medical school training programs in medicine and surgery in the United States of America. The board approves resident training programs accredited by ACGME.

“*AMA*” means the American Medical Association, a professional organization of physicians and surgeons.

“*Any jurisdiction*” means any state, the District of Columbia or territory of the United States of America or any other nation.

“*Any United States jurisdiction*” means any state, the District of Columbia or territory of the United States of America.

“*AOA*” means the American Osteopathic Association, which is the representative organization for osteopathic physicians (D.O.s) in the United States. The board approves osteopathic medical education programs with AOA accreditation; the board approves AOA-accredited resident training programs in osteopathic medicine and surgery at hospitals for graduates of accredited osteopathic medical schools. The board recognizes specialty board certification by AOA. The board recognizes continuing medical education accredited by the Council on Continuing Medical Education of AOA.

“*Applicant*” means a person who seeks authorization to practice medicine and surgery or osteopathic medicine and surgery in this state by making application to the board.

“*Approved abuse education training program*” means a training program using a curriculum approved by the abuse education review panel of the department of public health or a training program offered by a hospital, a professional organization for physicians, or the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“*Board*” means Iowa board of medicine.

“*Board-approved resident training program*” means a hospital-affiliated graduate medical education program accredited by ACGME, AOA, RCPSC, or CFPC at the time the applicant is enrolled in the program.

“*Candidate*” means a person who applies to sit for an examination administered by the board or its designated testing service.

“*Category 1 credit*” means any formal education program which is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of AOA that is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained by the physician completing the program. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“*CFPC*” means the College of Family Physicians of Canada, an organization that accredits graduate medical education in family practice in Canada.

“*COMLEX*” means the Comprehensive Osteopathic Medical Licensing Examination that is recognized by the board as the licensure examination that replaced the NBOME examination for graduates of osteopathic medical schools or colleges.

“*Committee*” means the licensure committee of the board.

“*COMVEX-USA*” means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America. The National Board of Osteopathic Medical Examiners prepares the examination and determines its passing score. A licensing authority in any jurisdiction administers the examination. COMVEX-USA is the current evaluative instrument offered to osteopathic physicians who need to demonstrate current osteopathic medical knowledge.

“*Core credentials*” means those documents that demonstrate the applicant’s identity, medical training and practice history. “Core credentials” includes but is not limited to: medical school diploma, medical school transcript, dean’s letter, examination history, ECFMG certificate, fifth pathway certificate, and postgraduate training verification.

“*Current, active status*” means a license that is in effect and grants the privilege of practicing medicine and surgery or osteopathic medicine and surgery, as applicable.

“*ECFMG*” means the Educational Commission for Foreign Medical Graduates, an organization that assesses the readiness of foreign medical school graduates to enter ACGME-approved residency programs in the United States of America.

“*Expedited endorsement*” means the process whereby the state issues an unrestricted license to practice medicine to an applicant who holds a valid unrestricted and unlimited license in another jurisdiction through the acceptance of the applicant’s core credentials that have been subject to primary source verification by another jurisdiction’s physician licensing board or other authority using a process substantially similar to Iowa’s process for verifying the authenticity of the applicant’s core credentials.

“*FCVS*” means the Federation Credentials Verification Service, a service under the Federation of State Medical Boards that verifies and stores core credentials for retrieval whenever needed.

“*FLEX*” means the Federation Licensing Examination, a licensure examination used in the past that was approved by the board for graduates with a medical degree.

“*Foreign medical school,*” also known as an “international medical school,” means a medical school that is located outside of any United States jurisdiction.

“*FSMB*” means the Federation of State Medical Boards, the organization of medical boards of the United States of America.

“*Inactive license*” means any license that is not in current, active status. Inactive license may include licenses formerly known as delinquent, lapsed, or retired. A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice medicine under an Iowa license until the license is reinstated to current, active status.

“*Incidentally called into this state in consultation with a physician and surgeon licensed in this state*” as set forth in Iowa Code section 148.2(5) means all of the following shall be true:

1. The consulting physician shall be involved in the care of patients in Iowa only at the request of an Iowa-licensed physician.
2. The consulting physician has a license in good standing in another United States jurisdiction.
3. The consulting physician provides expertise and acts in an advisory capacity to an Iowa-licensed physician. The consulting physician may examine the patient and advise an Iowa-licensed physician as to the care that should be provided, but the consulting physician may not personally perform procedures, write orders, or prescribe for the patient.
4. The consulting physician practices in Iowa for a period not greater than 10 consecutive days and not more than 20 total days in any calendar year. Any portion of a day counts as one day.
5. The Iowa-licensed physician requesting the consultation retains the primary responsibility for the management of the patient’s care.

“*Initial license*” means the first permanent license granted to a qualified individual.

“*International medical school,*” also known as a “foreign medical school,” means a medical school that is located outside of any United States jurisdiction.

“*LCME*” means Liaison Committee on Medical Education, an organization that accredits educational institutions granting degrees in medicine and surgery. The board approves programs that are accredited by LCME.

“*LMCC*” means enrollment in the Canadian Medical Register as Licentiate of Medical Council of Canada with a certificate of registration as proof. LMCC requires passing the Medical Council of Canada Examination.

“*Medical degree*” means a degree of doctor of medicine and surgery or osteopathic medicine and surgery or comparable education from a foreign medical school.

“*National Practitioner Data Bank*” is a national data bank of disciplinary actions taken against health professionals, including physicians.

“*NBME*” means the National Board of Medical Examiners, an organization that prepares and administers qualifying examinations, either independently or jointly with other organizations.

“*NBOME*” means the National Board of Osteopathic Medical Examiners, an organization that prepares and administers qualifying examinations for osteopathic physicians.

“*Observer*” means a person who is not enrolled in an Iowa medical school or osteopathic medical school, who observes care to patients in Iowa for a defined period of time and for a noncredit experience, and who is supervised and accompanied by an Iowa-licensed physician as defined in 9.2(3). An observer shall not provide or direct hands-on patient care, regardless of the observer’s level of training or supervision. The supervising physician may authorize an observer to read a chart, observe a patient interview or examination, or witness procedures, including surgery. An observer shall not chart; touch a patient as part of an examination; conduct an interview; order, prescribe or administer medications; make decisions that affect patient care; direct others in providing patient care; or conduct procedures, including surgery. Any of these activities requires licensure to practice in Iowa. An unlicensed physician observer or a medical student observer may touch a patient to verify a physical finding in the immediate presence of a physician but shall not conduct a more inclusive physical examination.

An unlicensed physician observer may:

1. Participate in discussions regarding the care of individual patients, including offering suggestions about diagnosis or treatment, provided the unlicensed physician observer does not direct the care; and
2. Elicit information from a patient provided the unlicensed physician observer does not actually perform a physical examination or otherwise touch the patient.

“*Permanent licensure*” means licensure granted after review of the application and credentials to determine that the individual is qualified to enter into practice. The individual may only practice when the license is in current, active status.

“*Practice*” means the practice of medicine and surgery or osteopathic medicine and surgery.

“*Primary source verification*” means:

1. Verification of the authenticity of documents with the original source that issued the document.
2. Original source verification by another jurisdiction’s physician licensing organization.
3. Original source verification by the FSMB’s Federation Credentials Verification Service.

“*RCPSC*” means the Royal College of Physicians and Surgeons of Canada, an organization that accredits graduate medical education in Canada.

“*Reinstatement*” means the process for returning an inactive license to current, active status.

“*Relinquishment*” means that a person’s permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine is deemed abandoned if the person fails to renew or reinstate the license within five years after its expiration. A license that has been relinquished is no longer valid or renewable. Relinquishment is not disciplinary in nature.

“*Resident physician*” means a physician enrolled in an internship, residency or fellowship.

“*Resident training program*” means a hospital-affiliated graduate medical education program that enrolls interns, residents or fellows and may be referred to as a postgraduate training program for purposes of licensure.

“*Service charge*” means the amount charged for making a service available on line and is in addition to the actual fee for a service itself. For example, one who renews a license on line will pay the license renewal fee and a service charge.

“*SPEX*” means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction. The passing score on SPEX is 75.

“*Training for chronic pain management*” means required training on chronic pain management identified in 653—Chapter 11.

“*Training for end-of-life care*” means required training on end-of-life care identified in 653—Chapter 11.

“*Training for identifying and reporting abuse*” means training on identifying and reporting child abuse or dependent adult abuse required of physicians who regularly provide primary health care to children or adults, respectively, as specified in 653—Chapter 11. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69; the full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“*Uniform application for physician state licensure*” means a Web-based application that is intended to standardize and simplify the licensure application process for state medical licensure. The Federation of State Medical Boards created and maintains the application. This application is used for all license types issued by the Iowa board of medicine.

“*USMLE*” means the United States Medical Licensing Examination.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 2346C, IAB 1/6/16, effective 2/10/16]

### **653—9.2(147,148) General licensure provisions.**

**9.2(1) Licensure required.** Licensure is required for practice in Iowa as identified in Iowa Code section 148.1; the exceptions are identified in subrule 9.2(2). Provisions for permanent physician licensure are found in this chapter; provisions for resident, special and temporary physician licensure are found in 653—Chapter 10.

**9.2(2) Licensure not required.** The following persons are not required to obtain a license to practice in Iowa:

*a.* Those persons described in Iowa Code sections 148.2(1) to 148.2(5).

(1) A medical student or osteopathic medical student in an international medical school may not take on the role of a medical student in the patient care setting unless the student is enrolled in the University of Iowa’s Carver College of Medicine or in Des Moines University’s College of Osteopathic Medicine; however, an international medical student not enrolled at either of these institutions may be an observer as defined in rule 653—9.1(147,148).

(2) A graduate of an international medical school shall not practice medicine without an Iowa medical license; however, the graduate may be an observer as defined in rule 653—9.1(147,148).

*b.* Those persons who are incidentally called into this state in consultation with a physician or surgeon licensed in this state as described in Iowa Code section 148.2(5) and as defined in rule 653—9.1(147,148).

*c.* Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa on a temporary basis to aid disaster victims at the time of a disaster in accordance with Iowa Code section 29C.6.

*d.* Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come to Iowa to participate in further medical education may participate in patient care under the request and supervision of the patient’s Iowa-licensed physician in charge of the education. The Iowa-licensed physician shall retain the primary responsibility for management of the patient’s care.

*e.* Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa to serve as expert witnesses as long as they do not provide treatment.

*f.* Physicians and surgeons from out of state who hold a current, active license in good standing in another United States jurisdiction and who accompany one or more individuals into Iowa for the purpose of providing medical care to these individuals on a short-term basis, e.g., a team physician for an out-of-state college football team that comes into Iowa for a game.

g. Physicians and surgeons who come to Iowa to observe patient care and who do not provide or direct hands-on patient care.

h. Visiting resident physicians who come to Iowa to practice as part of their resident training program if under the supervision of an Iowa-licensed physician. An Iowa physician license is not required of a physician in training if the physician has a resident or permanent license in good standing in the home state of the resident training program. An Iowa temporary license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident training program (see rule 653—10.5(147,148)).

**9.2(3) *Supervision of an observer.*** An Iowa-licensed physician who supervises an observer shall accompany the observer and solicit consent from each patient, where feasible, for the observation. The physician shall inform the patient of the observer's background, e.g., high school student considering a medical career, a medical graduate who is working on licensure. The supervising physician shall ensure that the observer remains within the scope of an observer as defined in rule 653—9.1(147,148).

[ARC 0215C, IAB 7/25/12, effective 8/29/12]

### **653—9.3(147,148) Eligibility for permanent licensure.**

**9.3(1) Requirements.** To be eligible for permanent licensure, an applicant shall meet all of the following requirements:

a. Fulfill the application requirements specified in rule 653—9.4(147,148), 653—9.5(147,148) or 653—9.6(147,148).

b. Hold a medical degree from an educational institution approved by the board at the time the applicant graduated and was awarded the degree.

(1) Educational institutions approved by the board shall be fully accredited by an accrediting agency recognized by the board as schools of instruction in medicine and surgery or osteopathic medicine and surgery and empowered to grant academic degrees in medicine.

(2) The accrediting bodies currently recognized by the board are:

1. LCME for the educational institutions granting degrees in medicine and surgery; and
2. AOA for educational institutions granting degrees in osteopathic medicine and surgery.

(3) If the applicant holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the applicant shall meet one of the following requirements:

1. Hold a valid certificate issued by ECFMG;
2. Have successfully completed a fifth pathway program established in accordance with AMA criteria;

3. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and have successfully completed three years of resident training in a program approved by the board; and have submitted evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction; or

4. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and hold board certification by a specialty board approved by ABMS or AOA; and submit evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction.

c. Have successfully completed one year of resident training in a hospital-affiliated program approved by the board at the time the applicant was enrolled in the program. An applicant who is a graduate of an international medical school shall have successfully completed 24 months of such training.

(1) For those required to have 12 months of training, the program shall have been 12 months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board. For those required to have 24 months of training, the program shall have been 24 continuous months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board.

(2) Resident training approved by the board shall be accredited by an accrediting agency recognized by the board for the purpose of accrediting resident training programs.

(3) The board approves resident training programs accredited by:

1. ACGME;
2. AOA;
3. RCPSC; and
4. CFPC.

(4) The board shall accept each 12 months of practice as a special licensee as equivalent to one year of resident training in a hospital-affiliated program approved by the board.

*d.* Pass one of the licensure examinations or combinations as prescribed in rule 653—9.7(147,148).

**9.3(2)** Reserved.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12]

**653—9.4(147,148) Licensure by examination.**

**9.4(1) Applicant eligibility.** An applicant who has never been licensed in any United States or Canadian jurisdiction shall meet the following requirements to be eligible for permanent licensure by examination.

**9.4(2) Requirements.** To apply for permanent licensure, an applicant shall:

*a.* Pay a nonrefundable initial application fee of \$450 plus the \$45 fee identified in 653—subrule 8.4(6) for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI); and

*b.* Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

*c.* Pass the USMLE, COMLEX, or Medical Council of Canada Examination as prescribed in rule 653—9.7(147,148) and authorize the testing authority to verify scores.

**9.4(3) Application.** The application shall require the following information:

*a.* Full legal name, date and place of birth, home address, mailing address and principal business address.

*b.* A photograph of the applicant suitable for positive identification.

*c.* A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

*d.* A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application.

*e.* A certified statement of scores on any licensure examination required in rule 653—9.7(147,148) that the applicant has taken in any jurisdiction. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*f.* A photocopy of the applicant's medical degree issued by an educational institution.

(1) A complete translation of any diploma not written in English shall be submitted. An official transcript, written in English and received directly from the school, showing graduation from medical school is a suitable alternative.

(2) An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

(3) If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

*g.* A sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

*h.* An official transcript, or its equivalent, received directly from the school for every medical school attended if requested by the board. A complete translation of any transcript not written in English shall be submitted if requested by the board. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*i.* If the educational institution awarding the applicant the degree has not been approved by the board, the applicant shall provide a valid ECFMG certificate or evidence of successful completion of a fifth pathway program in accordance with criteria established by AMA. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*j.* Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)“*c.*” An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*k.* Verification of an applicant’s hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

*l.* A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

*m.* A statement of the applicant’s physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care.

*n.* A statement disclosing and explaining the applicant’s involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.

*o.* A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending.

*p.* A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14]

### **653—9.5(147,148) Licensure by endorsement.**

**9.5(1) Applicant eligibility.** An applicant who has been licensed in any United States jurisdiction or Canada shall meet one of the following requirements to be eligible for permanent licensure by endorsement.

*a.* Applicants who have been licensed for at least five years may meet expedited endorsement requirements set forth in rule 653—9.6(147,148).

*b.* An M.D. applicant who has been licensed in any United States jurisdiction or Canada shall meet the licensure examination requirements in effect in Iowa at the time of original licensure if the examination precedes USMLE. An M.D. applicant who has been licensed in any United States jurisdiction or Canada based on USMLE shall meet the requirements in rule 653—9.7(147,148). The applicant shall authorize the appropriate testing authority to verify scores obtained on the examination as specified in this rule.

*c.* A D.O. applicant who has been licensed in any United States jurisdiction shall meet the licensure examination requirements in effect in Iowa at the time of original licensure if the examination precedes USMLE or COMLEX, whichever is applicable. A D.O. applicant who has been licensed in any United States jurisdiction based on USMLE or COMLEX shall meet the requirements in rule 653—9.7(147,148). The applicant shall authorize the appropriate testing authority to verify scores obtained on the examination as specified in this rule.

**9.5(2) Requirements.** To apply for permanent licensure, an applicant shall:

*a.* Pay a nonrefundable initial application fee of \$450 plus the \$45 fee identified in 653—subrule 8.4(6) for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI); and

*b.* Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

**9.5(3) Application.** The application shall require the following information:

*a.* Full legal name, date and place of birth, home address, mailing address and principal business address.

*b.* A photograph of the applicant suitable for positive identification.

*c.* A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

*d.* A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application.

*e.* A certified statement of scores on any examination required in rule 653—9.7(147,148) that the applicant has taken in any jurisdiction. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*f.* A photocopy of the applicant's medical degree issued by an educational institution.

(1) A complete translation of any diploma not written in English shall be submitted. An official transcript, written in English and received directly from the school, showing graduation from medical school is a suitable alternative.

(2) An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

(3) If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

*g.* A sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

*h.* An official transcript, or its equivalent, received directly from the school for every medical school attended if requested by the board. A complete translation of any transcript not written in English shall be submitted if requested by the board. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*i.* If the educational institution awarding the applicant the degree has not been approved by the board, the applicant shall provide a valid ECFMG certificate or evidence of successful completion of a fifth pathway program in accordance with criteria established by AMA. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*j.* Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)“c.” An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

*k.* Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

*l.* A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

*m.* A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care.

*n.* A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.

*o.* A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending.

*p.* A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14]

### **653—9.6(147,148) Licensure by expedited endorsement.**

**9.6(1) Applicant eligibility.** An applicant who has been licensed in any United States jurisdiction or Canada for more than five years shall meet the following requirements to be eligible for permanent licensure by expedited endorsement.

**9.6(2) Requirements.** To apply for permanent licensure by expedited endorsement, an applicant shall:

*a.* Pay a nonrefundable initial application fee of \$450 plus the \$45 fee identified in 653—subrule 8.4(6) for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI); and

*b.* Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

*c.* Meet the eligibility requirements set forth in subrule 9.3(1).

*d.* Be licensed in at least one other United States jurisdiction or Canadian province.

*e.* Hold an unrestricted license in every jurisdiction in which the applicant is licensed.

*f.* Have no formal disciplinary actions; no active or pending investigations; no past, pending, public or confidential restrictions or sanctions by a board of medicine, licensing authority, medical society, professional society, hospital, medical school, federal agency, or institution staff sanctions in any state, country or jurisdiction.

*g.* Hold current specialty board certification by an ABMS or AOA specialty board. Lifetime certification is excluded.

*h.* Have been engaged in continuous, active practice within the five years immediately preceding the date of submitting an application for licensure. Continuous, active practice includes private practice, employment in a hospital or clinical setting, employment by any governmental entity in community or public health, or practice of administrative, academic or research medicine. Continuous, active practice does not include residency, fellowship or postgraduate training of any kind.

**9.6(3) Application.** The application shall require the following information:

*a.* Full legal name, date and place of birth, home address, mailing address and principal business address.

*b.* A photograph of the applicant suitable for positive identification.

*c.* A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

*d.* A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application.

*e.* Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

*f.* A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

*g.* A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care.

*h.* A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.

*i.* A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending.

*j.* A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

NOTE: The board reserves the right to request information listed in rule 653—9.5(147,148).  
[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14]

### **653—9.7(147,148) Licensure examinations.**

#### **9.7(1) USMLE.**

*a.* The USMLE is a joint program of FSMB and the NBME. The USMLE is a multipart examination consisting of Step 1, Step 2, and Step 3. Steps 1 and 2 are administered by NBME and ECFMG. The board contracts with FSMB for the administration of Step 3. USMLE Steps 1 and 2 were implemented in 1992; Step 3 was implemented in 1994.

*b.* Since 1999, Step 3 is a computerized examination offered at testing centers in the Des Moines area and other locations around Iowa and the United States.

*c.* Applications are available at Department of Examination Services, FSMB, 400 Fuller Wisner Road, Suite 300, Eules, Texas 76039, or [www.fsmb.org](http://www.fsmb.org).

*d.* Candidates who meet the following requirements are eligible to take USMLE Step 3:

(1) Submit a completed application form and pay the required examination fee as specified in 653—subrule 8.3(1).

(2) Document successful completion of USMLE Steps 1 and 2 in accordance with the requirements of NBME. Graduates of a foreign medical school shall meet the requirements of ECFMG.

(3) Document holding a medical degree from a board-approved educational institution. If a candidate holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the candidate shall meet the requirements specified in 9.3(1)“c”(3).

(4) Document successful completion of a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Step 3 or enrollment in a resident training program approved by the board at the time of the application for Step 3.

*e.* The following conditions shall apply to applicants for licensure in Iowa who utilize USMLE as the licensure examination.

(1) Passing Steps 1, 2, and 3 is required within a ten-year period beginning with the date of passing either Step 1 or Step 2, whichever occurred first. Board certification by the ABMS or AOA is required if the applicant was not able to pass Steps 1, 2, and 3 within the required time as specified in this paragraph.

(2) Step 3 may be taken and passed only after Steps 1 and 2 are passed.

(3) A score of 75 or better on each step shall constitute a passing score on that step.

(4) Each USMLE step must be passed individually, and individual step scores shall not be averaged to compute an overall score.

(5) A failure of any USMLE step, regardless of the jurisdiction for which it was taken, shall be considered a failure of that step for the purposes of Iowa licensure.

(6) Successful completion of a progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Step 1 or six attempts on Step 2 CK and Step 2 CS combined or three attempts on Step 3.

*f.* Any candidate deemed eligible to sit for USMLE Step 3 is required to adhere to the examination procedures and protocol established by FSMB and NBME in the following publications: USMLE Test Administration Standards and Policies and Procedures Regarding Indeterminate Scores and Irregular Behavior, FSMB, 400 Fuller Wiser Road, Suite 300, Eules, Texas 76039.

**9.7(2) NBME.**

*a.* NBME Part Examinations (Parts I, II, and III) were first administered in 1916. The last regular administration of Part I occurred in 1991, Part II in April 1992, and Part III in May 1994.

*b.* Successful completion of NBME Parts I, II, and III was a requirement for NBME certification.

*c.* A score of 75 or better on each part shall constitute a passing score on that part.

**9.7(3) FLEX.**

*a.* From 1968 to 1985, (Old) FLEX was a three-day examination. Day 1 covered basic science; Day 2 covered clinical science; and Day 3 covered clinical competency. Applicants who took Old FLEX shall provide evidence of successful achievement of at least two of the following:

(1) Certification under seal that the applicant passed FLEX with a FLEX-weighted average of 75 percent or better, as determined by the state medical licensing authority, in no more than two sittings.

(2) Verification under seal of medical licensure in the state that administered the examination.

(3) Evidence of current certification by an American specialty board approved or recognized by the Council of Medical Education of AMA, ABMS, or AOA.

*b.* From 1985 to 1994, (New) FLEX replaced the Old FLEX. New FLEX was a three-day nationally standardized examination consisting of two, one and one-half day components referred to as Component I (basic and clinical science principles and mechanisms underlying disease and modes of therapy) and Component II (knowledge and cognitive abilities required of a physician assuming independent responsibility for the general delivery of medical care to patients). The last regular administration of both components of New FLEX occurred in 1993. Two special administrations of New FLEX Component I were offered in 1994 to examinees who passed Component II but not Component I prior to 1994. To be eligible for permanent licensure, the candidate must have passed both components in Iowa with a FLEX score of 75 or better within a seven-year period beginning with the date of initial examination.

(1) Candidates who took the FLEX for the first time were required to take both components during the initial sitting. A candidate who failed either or both components must have repeated and passed the component failed, though Component II could only be repeated if the candidate had received a passing score of 75 percent or better on Component I.

(2) Eligible candidates were permitted to sit for the initial examination and reapply to the board to repeat a failed component or complete the entire examination two additional times. However, candidates who failed either or both components three times were required to wait one year, during which time the candidate was encouraged to obtain additional training, before being permitted to sit two additional times for either or both components of the FLEX.

**9.7(4) Combination examination sequences.** To accommodate individuals who had already passed some part of the NBME Parts or FLEX before implementation of the USMLE, the USMLE program recommended and the board approved the following licensing combinations of examinations for licensure only if completed prior to January 1, 2000. These combinations are now only acceptable from an applicant who already holds a license from any United States jurisdiction.

*a.* FLEX Component I plus USMLE Step 3 with a passing score of 75 or better on each examination;

*b.* NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus FLEX Component II with a passing score of 75 or better on each examination; or

*c.* NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus NBME Part III or USMLE Step 3 with a passing score of 75 or better on each examination.

**9.7(5) Examinations for graduates of board-approved colleges of osteopathic medicine and surgery.**

*a.* COMLEX.

(1) COMLEX is a three-level examination that replaced the three-part NBOME examination. COMLEX Level 3 was first administered in February 1995; Level 2 was first administered in March

1997; and Level 1 was first administered in June 1998. All three examinations must be successfully completed in sequential order within ten years of the successful completion of COMLEX Level 1. Board certification by the ABMS or AOA is required if the applicant was not able to pass Levels 1, 2, and 3 within the required time as specified in this paragraph.

(2) A standard score of 400 on Level 1 or Level 2 is required to pass the examination. A standard score of 350 on Level 3 is required to pass the examination.

(3) A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Level 3 or enrollment in a resident training program approved by the board at the time of the application for Level 3.

(4) Successful completion of a progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Level 1 or six attempts on Level 2 CE and Level 2 PF combined or three attempts on Level 3.

(5) Each COMLEX level must be passed individually, and individual level scores shall not be averaged to compute an overall score.

(6) Level 3 may be taken and passed only after Levels 1 and 2 are passed.

(7) A failure of any COMLEX level, regardless of the jurisdiction for which it was taken, shall be considered a failure of that level for the purposes of Iowa licensure.

*b. NBOME.* The board accepts a passing score on the NBOME licensure examination for graduates of colleges of osteopathic medicine and surgery in any United States jurisdiction.

(1) NBOME was a three-part examination. All three parts must have been successfully completed in sequential order within seven years of the successful completion of NBOME Part 1.

(2) A passing score is required on each part of the examination.

(3) A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for NBOME Part 3. Candidates shall have completed their resident training by the last day of the month in which the examination was taken.

(4) Successful completion of a three-year resident training program is required if the applicant passes the examination after more than six attempts on Part 1 or six attempts on Part 2 or three attempts on Part 3.

(5) Each NBOME part must have been passed individually, and individual part scores shall not be averaged to compute an overall score.

(6) Part 3 must have been taken and passed only after Parts 1 and 2 were passed.

(7) A failure of any NBOME part, regardless of the jurisdiction for which it was taken, shall be considered a failure of that part for the purposes of Iowa licensure.

**9.7(6) LMCC.**

*a.* The board accepts toward Iowa licensure a verification of a Licentiate's registration with the Medical Council of Canada, based on passing the Medical Council of Canada Examination.

*b.* The Medical Council of Canada may be contacted at P.O. Box/CP 8234, Station 'T', Ottawa, Ontario, Canada K1G 3H7 or (613)521-9417.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12]

**653—9.8(147,148) Permanent licensure application review process.** The process below shall be utilized to review each application. Priority shall be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

**9.8(1)** An application for initial licensure shall be considered open from the date the application form is received in the board office with the nonrefundable initial licensure fee.

**9.8(2)** After reviewing each application, staff shall notify the applicant about how to resolve any problems. An applicant shall provide additional information when requested by staff or the board. Staff shall refer an expedited endorsement applicant to the process for licensure by endorsement or to the committee if:

*a.* The applicant does not meet the requirements set forth in rule 653—9.6(147,148) for expedited endorsement; or

*b.* Staff has reasonable concerns about the accuracy or thoroughness of another jurisdiction's licensing process.

**9.8(3)** If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

**9.8(4)** If the final review indicates questions or concerns that cannot be remedied by continued communication with the physician, the executive director, director of licensure and administration and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

*a.* If there is no current concern, staff shall administratively grant the license.

*b.* If any concern exists, the application shall be referred to the committee.

**9.8(5)** Staff shall refer to the committee for review matters which include but are not limited to: falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

**9.8(6)** If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant the license administratively.

**9.8(7)** If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

*a.* Request an investigation;

*b.* Request that the applicant appear for an interview;

*c.* If the physician has not engaged in active practice in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

*d.* Grant a license;

*e.* Grant a license under certain terms and conditions or with certain restrictions;

*f.* Request that the applicant withdraw the licensure application; or

*g.* Deny a license.

**9.8(8)** The board shall consider applications and recommendations from the committee and shall:

*a.* Request further investigation;

*b.* Require that the applicant appear for an interview;

*c.* If the physician has not engaged in active practice in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

*d.* Grant a license;

*e.* Grant a license under certain terms and conditions or with certain restrictions;

*f.* Request that the applicant withdraw the licensure application; or

*g.* Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.15(147,148).

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12]

**653—9.9(147,148) Licensure application cycle.**

**9.9(1) Failure to submit application materials.** If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status.

**9.9(2) Reactivation of the application.** To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee of \$150 and shall update credentials.

*a.* The period for requesting reactivation is limited to 90 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

*b.* The period for reactivation of application shall extend 90 days from the date the request and fee are received in the board office. During this period, the applicant shall update credentials and submit the remaining requested materials unless granted an extension in writing by the committee or the board.

*c.* Once the reactivation period expires, an applicant must reapply and submit a new nonrefundable application fee and a new application, documents and credentials.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12]

**653—9.10(147,148) Discretionary board actions on licensure applications.** As circumstances warrant, the board may determine that any applicant for licensure is subject to the following:

**9.10(1)** The board may impose limits or restrictions on the practice of any applicant once licensed in this state that are equal in force to the limits or restrictions imposed on the applicant by any jurisdiction.

**9.10(2)** The board may defer final action on an application for licensure if there is an investigation or disciplinary action pending against an applicant in any jurisdiction until such time as the board is satisfied that licensure of the applicant poses no risk to the health and safety of Iowans.

**9.10(3)** The board is not precluded from taking disciplinary action after licensure is granted related to issues that arose in the licensure application process.

[ARC 8554B, IAB 3/10/10, effective 4/14/10]

**653—9.11(147,148) Issuance of a permanent license.**

**9.11(1) Issuance.** Upon the granting of permanent licensure, staff shall issue an original license to practice that shall expire on the first day of the licensee's birth month.

*a.* Licenses of persons born in even-numbered years shall expire in an even-numbered year, and licenses of persons born in odd-numbered years shall expire in an odd-numbered year.

*b.* The license shall not be issued for a period less than two months or greater than two years and two months, in accordance with the licensee's month and year of birth.

*c.* When a resident physician receives a permanent Iowa license, the resident physician license shall immediately become inactive.

*d.* When a physician with a special license receives a permanent Iowa license, the special license shall immediately become inactive.

**9.11(2) Display of license.** The original permanent license shall be displayed in the licensee's primary location of practice.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12]

**653—9.12(147,148) Notification required to change the board's data system.**

**9.12(1) Change of address.** A licensee shall notify the board of any change in the home address or the address of the place of practice within one month of making an address change.

**9.12(2) Change of name.** A licensee shall notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

**9.12(3) Deceased.** A licensee file shall be closed and labeled "deceased" when the board receives a copy of the physician's death certificate.

[ARC 8554B, IAB 3/10/10, effective 4/14/10]

**653—9.13(147,148) Renewal of a permanent license.**

**9.13(1) *Renewal notice.*** Staff shall send a renewal notice by regular mail to each licensee at the licensee's last-known address at least 60 days prior to the expiration of the license.

**9.13(2) *Licensee obligation.*** The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of responsibility for renewing that license.

**9.13(3) *Renewal application requirements.*** A licensee seeking renewal shall submit a completed renewal application; information on continuing education, training on chronic pain management, training on end-of-life care, and training on identifying and reporting abuse; and the required fee prior to the expiration date on the current license.

*a.* Renewal fee.

(1) The renewal fee is \$550 if renewal is made via paper application or \$450 if renewal is made via on-line application, per biennial period or a prorated portion thereof if the current license was issued for a period of less than 24 months.

(2) There is no renewal fee due for a physician who was on active duty in the U.S. armed forces, reserves or national guard during the renewal period. "Active duty" means full-time training or active service in the U.S. armed forces, reserves or national guard. A physician who fails to renew before the expiration of the license shall be charged a penalty fee as set forth in 653—paragraph 8.4(1) "d."

*b.* The requirements for continuing education and training on identifying and reporting abuse are found in 653—Chapter 11.

*c.* The first renewal fee shall be prorated on a monthly basis according to the date of issuance and the physician's month and year of birth, if the original permanent license was issued for a period of less than 24 months.

**9.13(4) *Issuance of a renewal.*** Upon receiving the completed renewal application, staff shall administratively issue a two-year license that expires on the first day of the licensee's birth month. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration.

**9.13(5) *Renewal penalties.*** If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, the licensee shall be charged a penalty fee as set forth in 653—paragraph 8.4(1) "d."

**9.13(6) *Failure to renew.*** Failure of the licensee to renew a license within two months following its expiration date shall cause the license to become inactive and invalid. A licensee whose license is invalid is prohibited from practice until the license is reinstated in accordance with rule 653—9.15(147,148).

*a.* In order to ensure that the license will not become inactive when a paper renewal form is used, the completed renewal application and appropriate fees must be received in the board office by the fifteenth of the month prior to the month the license becomes inactive. For example, a licensee whose license expires on January 1 has until March 1 to renew the license or the license becomes inactive and invalid. The licensee must submit and the board office must receive the renewal materials prior to or on February 15 to ensure that the license will be renewed prior to becoming inactive and invalid on March 1.

*b.* In order to ensure that the license will not become inactive when on-line renewal is used, the licensee must complete the on-line renewal prior to midnight of the last day of the month in the month after the expiration date on the license. For example, a licensee whose license expiration date is January 1 must complete the on-line renewal before midnight on the last day of February; the license becomes inactive and invalid at 12:01 a.m. on March 1.

**9.13(7) *Display of license.*** Renewal licenses shall be displayed along with the original permanent license in the primary location of practice.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 0871C, IAB 7/24/13, effective 8/28/13]

**653—9.14(147,148) Inactive status and reinstatement of a permanent license.**

**9.14(1)** *Definition of inactive status.* An inactive license is any license that is not a current, active license.

*a.* “Inactive status” may include licenses formerly known as delinquent, lapsed, or retired.

*b.* A physician with an inactive license may not practice medicine until the license is reinstated to current, active status.

*c.* A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice medicine under an Iowa license until the license is reinstated to current, active status. A licensee who practices under an Iowa license when the license is inactive may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, or other available legal remedies.

**9.14(2)** *Mechanisms for becoming inactive.* A licensee seeking to become inactive may do so by submitting a written request to the board office or by failing to renew a license by the first day of the third month after the expiration date. For example, a licensee whose license expires on January 1 will be considered inactive if the license is not renewed by March 1.

**9.14(3)** *Fee.* There is no fee to become inactive.

[ARC 8554B, IAB 3/10/10, effective 4/14/10]

**653—9.15(147,148) Reinstatement of an unrestricted Iowa license.**

**9.15(1)** *Reinstatement within one year of the license’s becoming inactive.* An individual whose license is in inactive status for up to one year and who wishes to reinstate the license shall submit a completed renewal application; documentation of continuing education; training on chronic pain management, training on end-of-life care, and training on identifying and reporting abuse; and the reinstatement fee. All of the information shall be received in the board office within one year of the license’s becoming inactive for the applicant to reinstate under this subrule. For example, a physician whose license became inactive on March 1 has until the last day of the following February to renew under this subrule.

*a.* *Fees for reinstatement within one year of the license’s becoming inactive.* The reinstatement fee is \$550 except when the license in the most recent license period had been granted for less than 24 months; in that case, the reinstatement fee is prorated according to the date of issuance and the physician’s month and year of birth.

*b.* *Continuing education and training requirements.* The requirements for continuing education, training on chronic pain management, training on end-of-life care, and training on identifying and reporting abuse are found in 653—Chapter 11. Applicants for reinstatement shall provide documentation of having completed:

(1) The number of hours of category 1 credit needed for renewal in the most recent license period. None of the credits obtained in the inactive period may be carried over to a future license period; and

(2) Training on chronic pain management, end-of-life care, and identifying and reporting abuse, if applicable, within the previous five years.

*c.* *Issuance of a reinstated license.* Upon receiving the completed application, staff shall administratively issue a license that expires on the renewal date that would have been in effect if the licensee had renewed the license before the license expired.

*d.* *Reinstatement application process.* The applicant who fails to submit all reinstatement information required within 365 days of the license’s becoming inactive shall be required to meet the reinstatement requirements of 9.15(2). For example, if a physician’s license expires on January 1, the completed reinstatement application is due in the board office by December 31, in order to meet the requirements of this subrule.

**9.15(2)** *Reinstatement of an unrestricted Iowa license that has been inactive for one year or longer.* An individual whose license is in inactive status and who has not submitted a reinstatement application that was received by the board within one year of the license’s becoming inactive shall follow the application cycle specified in this rule and shall satisfy the following requirements for reinstatement:

a. Submit an application for reinstatement to the board upon forms provided by the board. The application shall require the following information:

(1) Full legal name, date and place of birth, license number, home address, mailing address and principal business address;

(2) A chronology accounting for all time periods from the date of initial licensure;

(3) Every jurisdiction in which the applicant is or has been authorized to practice including license numbers and dates of issuance;

(4) Verification of the applicant's hospital and clinical staff privileges, and other professional experience for the past five years if requested by the board;

(5) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

(6) A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care;

(7) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(9) A completed fingerprint packet to facilitate a national criminal history background check. The \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

b. Pay the reinstatement fee of \$500 plus the \$45 fee identified in 653—subrule 8.4(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks. No fee is required for reinstatement for those whose licenses became inactive between December 8, 1999, and July 4, 2001; however, the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed.

c. Provide documentation of completion of 80 hours of category 1 credit within the previous two years and documentation of training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11.

d. If the physician has not engaged in active practice in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

e. An individual who is able to submit a letter from the board with different reinstatement or reactivation criteria is eligible for reinstatement based on those criteria.

**9.15(3) Reinstatement application cycle and process.** The cycle and process are the same as described in rules 653—9.8(147,148) and 653—9.9(147,148).

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14]

**653—9.16(147,148) Reinstatement of a restricted Iowa license.** A physician whose license has been suspended or revoked following a disciplinary proceeding is required to seek reinstatement pursuant to 653—Chapter 26.

[ARC 8554B, IAB 3/10/10, effective 4/14/10]

**653—9.17(147,148) Denial of licensure.**

**9.17(1) Preliminary notice of denial.** Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

**9.17(2) Appeal procedure.** An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure.

**9.17(3) Hearing.** If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with 653—25.30(17A).

- a. License denial hearings are contested cases open to the public.
- b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.
- c. Evidence supporting the denial of the license may be presented by an assistant attorney general.
- d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.
- e. The board, after a hearing on license denial, may grant or deny the application for licensure. The board shall state the reasons for its decision and may grant the license, grant the license with restrictions or deny the license. The final decision is a public record.
- f. Judicial review of a final order of the board denying licensure, or issuing a license with restrictions, may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

**9.17(4) Finality.** If an applicant does not appeal a preliminary notice of denial in accordance with 9.17(2), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

**9.17(5) Failure to pursue appeal.** If an applicant appeals a preliminary notice of denial in accordance with 9.17(2), but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

[ARC 7756B, IAB 5/6/09, effective 6/10/09; ARC 8554B, IAB 3/10/10, effective 4/14/10]

**653—9.18(17A,147,148,272C) Waiver or variance requests.** Waiver or variance requests shall be submitted in conformance with 653—Chapter 3.

[ARC 8554B, IAB 3/10/10, effective 4/14/10]

**653—9.19(147,148) Relinquishment of license to practice.** A person's permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine shall be deemed relinquished if the person fails to apply for renewal or reinstatement of the license within five years after its expiration.

**9.19(1)** A license shall not be reinstated, reissued, or restored once it is relinquished. The person may apply for a new license pursuant to Iowa Code sections 148.3 and 148.11 and 653—Chapters 9 and 10.

**9.19(2)** The relinquishment of license may be stayed if, at the date of relinquishment, there is an active:

- a. Evaluation order pursuant to Iowa Code section 272C.9(1) and rule 653—24.4(272);
  - b. Combined statement of charges and settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.3(17A);
  - c. Statement of charges pursuant to Iowa Code section 17A.12(2) and rule 653—25.4(17A);
  - d. Settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.17(272C);
  - e. Final decision pursuant to Iowa Code sections 17A.12 and 272C.6 and rule 653—25.24(17A);
- or
- f. Application for reinstatement of the license pursuant to rule 653—9.15(147,148) or 653—9.16(147,148).

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These rules are intended to implement Iowa Code chapters 17A, 147, 148, and 272C.

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## **NURSING BOARD[655]**

[Prior to 8/26/87, see Nursing, Board of[590], renamed Nursing Board[655]  
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CHAPTER 3  
LICENSURE TO PRACTICE—REGISTERED NURSE/LICENSED PRACTICAL NURSE

**655—3.1(17A,147,152,272C) Definitions.**

*“Accredited or approved nursing program”* means a nursing education program whose status has been recognized by the board or by a similar board in another jurisdiction that prepares individuals for licensure as a licensed practical nurse, registered nurse, or advanced registered nurse practitioner; or grants a baccalaureate, master’s or doctorate degree with a major in nursing.

*“Address”* means a street address in any state when a street address is available or a rural route address when a street address is not available.

*“Applicant”* means a person who is qualified to take the examination or apply for licensure by endorsement.

*“Endorsement”* means the process by which a registered nurse/licensed practical nurse licensed in another jurisdiction becomes licensed in Iowa.

*“Examination”* means the tests used to determine minimum competency prior to the issuance of a registered nurse/licensed practical nurse license.

*“Fees”* means those fees collected which are based upon the cost of sustaining the board’s mission to protect the public health, safety and welfare. The nonrefundable fees set by the board are as follows:

1. Application for original license based on the registered nurse examination, \$93 (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI)).

2. Application for original license based on the practical nurse examination, \$93 (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the DCI and the FBI).

3. Application for registered nurse/licensed practical nurse license by endorsement, \$119 (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the DCI and the FBI).

4. Application for original license or renewal as an advanced registered nurse practitioner, \$81 for any period of licensure up to three years.

5. For a certified statement that a registered nurse/licensed practical nurse is licensed in this state or registered as an advanced registered nurse practitioner, \$25.

6. For written verification of licensure status, not requiring certified statements, \$3 per license.

7. For reactivation of a license to practice as a registered nurse/licensed practical nurse, \$175 for a license lasting more than 24 months up to 36 months (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the DCI and the FBI).

8. For reactivation of a license to practice as an advanced registered nurse practitioner, \$81 for any period of licensure up to three years.

9. For the renewal of a license to practice as a registered nurse/licensed practical nurse, \$99 for a three-year period.

10. For a duplicate or reissued wallet card or original certificate to practice as a registered nurse, licensed practical nurse, or advanced registered nurse practitioner, \$20.

11. For late renewal of a registered nurse/licensed practical nurse license, \$50, plus the renewal fee as specified in paragraph “9” of this definition.

12. For a check returned for any reason, \$15. If licensure/registration has been issued by the board office based on a check for the payment of fees and the check is later returned by the bank, the board shall request payment by certified check or money order.

13. For a certified copy of an original document, \$20.

14. For special licensure, \$62.

15. For the evaluation of the fingerprint cards and the DCI and FBI criminal history background checks, \$50.

*“Inactive license”* means a registered nurse or licensed practical nurse license that has been placed on inactive status because it was not renewed by the fifteenth day of the month following the expiration date, or the board has received notification that a licensee has declared another compact state as primary

state of residency. Pursuant to 655—subrule 16.2(8), the former home state license shall no longer be valid upon the issuance of a new home state license.

“*Late license*” means a registered nurse or licensed practical nurse license that has not been renewed by the expiration date on the wallet card. The time between the expiration date and the fifteenth day of the month following the expiration date is considered a grace period.

“*Licensee*” means a person who has been issued a license to practice as a registered nurse, licensed practical nurse or advanced registered nurse practitioner under the laws of this state.

“*NCLEX®*” means National Council Licensure Examination for registered nurse/licensed practical nurse licensure.

“*Overpayment*” means payment in excess of the required fee. Overpayment less than \$10 received by the board shall not be refunded.

“*Reactivation*” means the process whereby an inactive licensee obtains a current license.

“*Reinstatement*,” pursuant to rule 655—20.36(17A,147,152,272C), means the process by which any person whose license to practice nursing has been suspended, revoked or voluntarily surrendered by order of the board may apply for license consideration.

“*Temporary license*” means a license issued on a short-term basis for a specified time pursuant to subrule 3.5(4).

“*Unlicensed student*” means a person enrolled in a nursing education program who has never been licensed as a registered nurse or licensed practical/vocational nurse in any U.S. jurisdiction.

“*Verification*” means the process whereby the board provides a certified statement that the license of a registered nurse/licensed practical nurse/advanced registered nurse practitioner is active, inactive, or encumbered/disciplined.

This rule is intended to implement Iowa Code sections 147.80 and 147.82.

[ARC 1130C, IAB 10/30/13, effective 12/4/13; ARC 1815C, IAB 1/7/15, effective 2/11/15; ARC 2339C, IAB 1/6/16, effective 2/10/16]

### **655—3.2(17A,147,152,272C) Mandatory licensure.**

**3.2(1)** A person who practices nursing in the state of Iowa as defined in Iowa Code section 152.1, outside of one’s family, shall have a current Iowa license, whether or not the employer is in Iowa and whether or not the person receives compensation. Any nurse who participates in the care of a patient situated in Iowa, whether that care is provided through telephonic, electronic or in-person means, and regardless of the location of the nurse, must obtain Iowa licensure unless specifically exempted by the licensure compact agreement. The nurse shall maintain verification of licensure and shall have it available for inspection when engaged in the practice of nursing in Iowa.

**3.2(2)** Current Iowa licensure is not mandatory when:

*a.* A nurse who resides in another party state is recognized for licensure in this state pursuant to the nurse licensure compact contained in Iowa Code chapter 152E. The nurse shall maintain verification of licensure and shall have it available for inspection when engaged in the practice of nursing in Iowa.

*b.* A nurse who holds an active license in another state provides services to patients in Iowa only during interstate transit.

*c.* A nurse who holds an active license in another state provides emergency services in an area in which the governor of Iowa has declared a state of emergency.

**3.2(3)** A nurse who is enrolled in an approved nursing program shall hold an active license in the U.S. jurisdiction(s) in which the nurse provides patient care.

This rule is intended to implement Iowa Code section 147.2.

[ARC 1815C, IAB 1/7/15, effective 2/11/15]

### **655—3.3(17A,147,152,272C) Licensure qualifications for registered nurse and licensed practical nurse.**

**3.3(1)** Applicants shall meet the requirements set forth in Iowa Code sections 147.3 and 152.7. Requirements include:

*a.* Graduation from an approved nursing program preparing registered nurses as defined in Iowa Code section 152.5(1) for registered nurse applicants or graduation from an approved nursing

program preparing practical nurses as defined in Iowa Code section 152.5(1) for licensed practical nurse applicants.

*b.* Passing NCLEX® or the State Board Test Pool Examination, the national examination used prior to 1982.

*c.* Board approval of an applicant with a criminal history or a record of prior disciplinary action, regardless of jurisdiction.

**3.3(2)** The requirement listed in paragraph 3.3(1) “*b*” is subject to the following exceptions:

*a.* A practical nurse applicant must have written the same examination as that administered in Iowa and achieved a score established as passing for that test by the board unless the applicant graduated and was licensed prior to July 1951.

*b.* An applicant whose national examination scores do not meet the Iowa requirements in effect at the time of the examination and who wishes to become licensed in Iowa may appeal to the board. The board may require the applicant to pass the current examination.

This rule is intended to implement Iowa Code sections 147.2 and 152.7(3).

[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.4(17A,147,152,272C) Licensure by examination.**

**3.4(1)** Applicants shall meet qualifications for licensure set forth in subrule 3.3(1).

**3.4(2)** The board contracts with the National Council of State Boards of Nursing, Inc. to use the NCLEX® for registered nurses and licensed practical nurses.

*a.* The NCLEX® is administered according to guidelines and passing standards established by the National Council of State Boards of Nursing, Inc.

*b.* NCLEX® results are reported as pass or fail.

*c.* Examination statistics are available to the public.

**3.4(3)** Application—graduates of approved programs.

*a.* The board shall:

(1) Provide information about licensure application to applicants, nursing education programs in Iowa, and others upon request.

(2) Determine eligibility of each applicant upon receipt of an application, fees, official nursing transcript, fingerprint cards and a signed waiver form.

*b.* The applicant shall:

(1) Submit a completed application for license by examination.

(2) Submit two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint cards and the DCI and FBI criminal history background checks will be assessed to the applicant.

(3) Submit fee for application for license by examination plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.

(4) Register for the NCLEX® and submit registration fee to the national test service agency.

(5) Direct the nursing program to submit to the board an official nursing transcript denoting the date of graduation and diploma or degree conferred.

(6) Inform the board that the primary state of residence is Iowa or a noncompact state and provide a current street address and mailing address, if different.

(7) Submit a copy of the court document(s) with the license application if the applicant has a criminal history.

(8) Complete NCLEX® registration through the national test service agency within 12 months of board receipt of the application for license, fingerprint cards, signed waiver form, and fees. The board reserves the right to destroy documents after 12 months.

(9) Self-schedule the examination with an approved testing center.

(10) Applicants who do not test within 91 days of authorization from the national test service agency are required to submit a new application and fee to the board.

**3.4(4)** Application—individuals educated and licensed in another country.

- a.* The board shall:
- (1) Provide information about licensure application to applicants and others upon request.
  - (2) Determine eligibility of each applicant upon receipt of:
    1. Application for license by examination.
    2. Two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check.
    3. Application fee for license by examination plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.
    4. Official nursing transcript denoting date of graduation validated by the Commission on Graduates of Foreign Nursing Schools (CGFNS) International.
    5. Validation of licensure/registration in the original country by CGFNS International.
    6. Credentials Evaluation Service Professional report submitted by CGFNS International for licensed practical nurse and registered nurse applicants.
    7. Verification of ability to read, write, speak and understand the English language as determined by the results of the International English Language Testing System (IELTS), Pearson Test of English Academic (PTE), or Test of English as a Foreign Language (TOEFL) for licensed practical nurse and registered nurse applicants. Applicants shall be exempt from the IELTS, PTE or TOEFL examination when the native language is English; nursing education was completed in a college, university or professional school located in Australia, Barbados, Canada (except Quebec), Ireland, Jamaica, New Zealand, South Africa, Trinidad and Tobago, or the United Kingdom; language of instruction in the nursing program was English; and language of the textbooks in the nursing program was English.
- b.* The applicant shall:
- (1) Submit completed application for license by examination, including two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check.
  - (2) Submit fee for application for license by examination plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.
  - (3) Register for the NCLEX® and submit registration fee to the national test service agency.
  - (4) Direct CGFNS International to validate the official nursing transcript.
  - (5) Direct CGFNS International to validate licensure/registration in the original country.
  - (6) Complete the Credentials Evaluation Service Professional report application through CGFNS International for licensed practical nurse and registered nurse applicants.
  - (7) Complete IELTS, PTE or TOEFL requirements for licensed practical nurse and registered nurse applicants, unless exempt.
  - (8) Inform the board of primary state of residence and a current street address and mailing address, if different.
  - (9) Submit a copy of the court document(s) with the license application if the applicant has a criminal history.
  - (10) Self-schedule the examination with an approved testing center.
  - (11) Complete NCLEX® registration through the national test service agency within 12 months of board receipt of the application for license, fingerprint cards, signed waiver form, and fees. The board reserves the right to destroy documents after 12 months.
  - (12) Applicants who do not test within 91 days of authorization from the national test service agency are required to submit a new application and fee to the board.
- 3.4(5) Application—individuals with disabilities.** Individuals with disabilities as defined in the Americans with Disabilities Act shall be provided modifications during the NCLEX®.
- a.* The board shall:
- (1) Notify applicants of the availability of test modifications for individuals with documented disabilities.
  - (2) Upon request, notify applicants of the process for obtaining board approval of test modification as defined in paragraph 3.4(5) “*b.*”

- (3) Determine eligibility for test modification upon receipt of:
  1. Written request from the applicant for test modifications during the NCLEX®.
  2. Written documentation of the applicant's disability and need for test modifications, including results of appropriate diagnostic testing, submitted by a qualified professional with expertise in the area of the diagnosed disability.
  3. Written documentation of test modifications, if any, granted to the applicant while enrolled in the nursing education program.
    - b. The applicant shall:
      - (1) Submit to the board a written request for specific modifications during the NCLEX®.
      - (2) Obtain appropriate documentation supporting the request for accommodations, including results of appropriate diagnostic testing, submitted by a qualified professional with expertise in the areas of the diagnosed disability. Documentation could include recent reports, test results, evaluations and assessments of the candidate's need for accommodations due to a disability (physical or mental impairment) that substantially limits one or more major life activities.
      - (3) Direct the nursing program to submit to the board documentation of test modifications provided to the applicant while enrolled in the nursing education program, if any were granted.
      - (4) Complete examination application requirements defined in subrule 3.4(3) or 3.4(4).

**3.4(6) Reexamination.**

- a. An applicant who has graduated from an approved practical nurse program and has failed the NCLEX-PN® is eligible to take the NCLEX-PN® an indefinite number of times.
- b. An applicant who has graduated from an approved registered nurse program and has failed the NCLEX-RN® is eligible to take the NCLEX-RN® an indefinite number of times.
- c. An applicant who fails the NCLEX® and reapplies within 12 months for license by examination shall be required to complete an application for license by examination, submit the fee for application by examination, complete NCLEX® registration and submit a registration fee to the national test service agency.
- d. An applicant who fails the NCLEX® and reapplies, after 12 months have passed, for license by examination shall be required to complete an application for license by examination, submit two completed fingerprint cards, a signed waiver form, and the fee for evaluation of the fingerprint cards and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), pursuant to rule 655—3.1(17A,147,152,272C), complete NCLEX® registration and submit a registration fee to the national test service agency.
- e. Applicants for the examination who do not appear for the appointment or do not complete the examination will be required to complete the examination requirements defined in paragraphs 3.4(6) "a" to "d."

**3.4(7) Certificate of license by examination.** Upon completion of the relevant qualifications for license by examination and passing of the NCLEX® as defined in these rules, the board shall issue a certificate of license by examination and a current license to practice as a registered nurse/licensed practical nurse. The board staff may issue a certificate of license prior to receipt of a report on the applicant from the DCI/FBI.

This rule is intended to implement Iowa Code sections 147.36, 147.80 and 152.7(3).  
[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 8810B, IAB 6/2/10, effective 7/7/10; ARC 1131C, IAB 10/30/13, effective 12/4/13; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.5(17A,147,152,272C) Licensure by endorsement.**

**3.5(1) Qualifications for licensure by endorsement.** The endorsee shall meet the qualifications for licensure defined in subrule 3.3(1).

**3.5(2) Applicants currently licensed in another state.** Application for licensure to practice as a registered nurse or licensed practical nurse by endorsement shall be made according to the following process:

- a. The board shall:
  - (1) Provide application forms and instructions to applicants upon request.

(2) Determine eligibility of each applicant upon receipt of an application, fees, official nursing transcript, and verification of license submitted by state of original license or the National Council of State Boards of Nursing, Inc., electronic nurse licensure system (NURSYS®).

*b.* The applicant shall:

(1) Submit a completed application form for license by endorsement.

(2) Submit two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint cards and the DCI and FBI criminal history background checks will be assessed to the applicant.

(3) Submit the fee for license by endorsement plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.

(4) Direct the nursing program to submit to the board an official nursing transcript denoting the date of graduation and diploma or degree conferred.

(5) Provide verification of state of original licensure by one of the following:

1. Submit the application form for verification of original licensure to state of original licensure.

2. Apply directly to the online verification system (NURSYS®) if the original state of licensure participates in NURSYS®.

(6) Attest that Iowa is the primary state of residence if the applicant is changing primary state of residence from another party state as outlined in rule 655—16.2(152E) or that the primary state of residence is a noncompact state. The board may request evidence of residency.

(7) Complete the application process within 12 months from the date of receipt of the application. The board reserves the right to destroy the documents after 12 months.

*c.* An endorsement applicant who has been disciplined by a licensing authority in another state must indicate the jurisdiction of the action(s) when submitting application materials. A copy of all relevant disciplinary documents will be obtained for board review prior to a determination regarding licensure. The board may impose conditions for licensure.

*d.* An endorsement applicant who has a criminal history must submit a copy of the court document(s) when submitting application materials. The board may impose conditions for licensure.

*e.* An applicant who fails to complete the licensure process within 12 months from the date of receipt of the application must reapply.

**3.5(3)** *Application—individuals educated and licensed in another country.*

*a.* The board shall:

(1) Provide application forms and instructions to applicants upon request.

(2) Determine eligibility of each applicant upon receipt of an application, two completed fingerprint cards and a signed waiver form, fees, official nursing transcript denoting date of graduation validated by CGFNS International, validation of licensure/registration in the original country by CGFNS International, Credentials Evaluation Service Professional report from CGFNS International, and verification of original license submitted by state of original license or the National Council of State Boards of Nursing, Inc., electronic nurse licensure system (NURSYS®).

*b.* The applicant shall:

(1) Submit completed application for licensure by endorsement, including two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check.

(2) Submit fee for application for licensure by endorsement plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.

(3) Direct CGFNS International to validate the official nursing transcript.

(4) Direct CGFNS International to validate licensure/registration in the original country.

(5) Complete the Credentials Evaluation Service Professional report application through CGFNS International for licensed practical nurse and registered nurse applicants, or direct CGFNS International to verify that a certificate letter was issued, or send the completed Credentials Evaluation Service Professional report to the board.

(6) Inform the board of primary state of residence and a current street address and mailing address, if different.

(7) Submit a copy of the court document(s) with the license application if an applicant has a criminal history.

**3.5(4) Temporary license.** A temporary license shall be issued to an applicant who is licensed in another state if the applicant meets the qualifications for a license as outlined in subrule 3.3(1). The application form and endorsement fee plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C), verification of license form and two completed fingerprint cards and signed waiver form to facilitate a national criminal history background check shall be on file in the office of the board prior to the issuance of the temporary license.

a. A temporary licensee may use the appropriate title of registered nurse or licensed practical nurse and the appropriate abbreviation R.N. or L.P.N.

b. The temporary wallet card must be signed by the licensee to be valid. The temporary license shall be issued for a period of 30 days. A second temporary license may be issued for a period not to exceed 30 days or at the discretion of the executive director.

c. A temporary license may be issued to an applicant who has incurred disciplinary action in another state when the license is not currently encumbered.

d. A temporary license may not be issued to an applicant with a criminal history.

e. A temporary license shall not be issued to an applicant educated and licensed in another country until the Credentials Evaluation Service Professional report application through CGFNS International has been received by the board, CGFNS International has verified that a certificate letter was issued, or CGFNS International submits a previously completed Credentials Evaluation Service Professional report to the board.

**3.5(5) Certificate of license by endorsement.** Upon completion of the endorsement procedures defined in these rules, the board shall issue a certificate of license by endorsement and a current license to practice as a registered nurse/licensed practical nurse. The board staff may issue a certificate of license prior to receipt of a report on the applicant from the DCI/FBI.

This rule is intended to implement Iowa Code sections 147.2 and 152.9.  
[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 8810B, IAB 6/2/10, effective 7/7/10; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.6(17A,147,152,272C) Special licensure for those licensed in another country.** A special license may be granted by the board on an individual basis to allow a nurse licensed in another country who is not eligible for endorsement to practice nursing in Iowa for a fixed period of time under certain conditions. Special licensure shall allow the nurse to provide care in a specialty area, provide consultation or teaching where care is directed, serve as a research or teaching assistant, or obtain clinically based continuing education.

1. Upon request, the board shall provide application materials to the applicant or sponsor.

2. The applicant shall provide identifying information, criminal history, history of licensure in another jurisdiction, and reason for special licensure.

3. The applicant shall complete the application, submit a fee as identified in rule 655—3.1(17A,147,152,272C), and provide evidence of certification by CGFNS International, official results of the TOEFL test or official results of the International English Language Testing System (IELTS). The applicant shall have a minimum score of 540 for the paper-based TOEFL test, a minimum score of 207 for the computer-based TOEFL test, or a minimum score of 83 for the Internet-based TOEFL test. The applicant shall score a minimum of 6.5 for the IELTS test.

4. Board staff shall determine the validity of the request based on the need, duration and location of special licensure identified on the application, and staff shall notify the applicant of ineligibility for special licensure if the application is incomplete or indicates a criminal history or evidence of licensure in another jurisdiction.

5. The board shall grant special licensure to eligible applicants. The license shall be identified as a special license and identify duration and conditions as designated in this rule. The period of special licensure shall be determined by the board and may be extended at the request of the applicant.

6. If the board denies special licensure, the individual may be eligible for licensure by examination in accordance with subrule 3.4(4).

7. The licensee shall be subject to all rules and regulations promulgated by the board except those pertaining to verification, renewal, late renewal, inactivation, reactivation and continuing education requirements.

This rule is intended to implement Iowa Code section 147.2.

[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.7(17A,147,152,272C) License cycle.**

**3.7(1) Name and address changes.** Written notification to the board of name and address changes is required within 30 days of the event. Licensure documents are mailed to the licensee at the address on file in the board office. There is no fee for a change of name or address in board records.

**3.7(2) New licenses.** The board shall issue licenses by endorsement and examination for a 24- to 36-month period. When the license is renewed, it will be placed on a three-year renewal cycle. Expiration shall be on the fifteenth day of the birth month.

**3.7(3) Renewal.** The licensee may renew the license beginning 60 days prior to license expiration. Renewal is available online at the board's Web site or by mail upon request. When the licensee has satisfactorily completed the requirements for renewal, a wallet card shall be mailed to the licensee.

*a.* The licensee shall:

(1) Attest that Iowa is the primary state of residence as outlined in rule 655—16.2(152E) or that the primary state of residence is a noncompact state. The board may request evidence of residency.

(2) Submit the renewal application and the renewal fee as specified in rule 655—3.1(17A,147,152, 272C).

(3) Meet the continuing education requirement as set forth in 655—Chapter 5, prior to license renewal.

(4) Complete the required mandatory reporter training set forth in paragraph 3.7(3)“*b.*”

*b.* Mandatory reporter training.

(1) The course shall be a curriculum approved by the Iowa department of public health.

(2) A licensee who regularly examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for rule suspension as identified in subparagraph 3.7(3)“*b*”(6).

(3) A licensee who regularly examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for rule suspension as identified in subparagraph 3.7(3)“*b*”(6).

(4) A licensee who regularly examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training on abuse identification and reporting in dependent adults and children or condition(s) for rule suspension as identified in subparagraph 3.7(3)“*b*”(6). Training may be completed through separate courses as identified in subparagraphs 3.7(3)“*b*”(2) and (3) or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse.

(5) The licensee shall maintain written documentation for five years after mandatory training as identified in subparagraphs 3.7(3)“*b*”(2) to (4), including program date(s), content, duration, and proof of participation.

(6) The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

1. Is engaged in active duty in the military service of this state or the United States.

2. Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including waiver of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 655—Chapter 5.

(7) The board may select licensees for audit of compliance with the requirements in subparagraphs 3.7(3)“b”(1) to (6).

**3.7(4) *Late renewal.*** The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in rule 655—3.1(17A,147,152,272C).

To renew a late license, the licensee shall complete the renewal requirements and submit the late fee before the fifteenth day of the month following the expiration date on the wallet card.

**3.7(5) *Inactive status.*** The license shall become inactive when the license has not been renewed by the fifteenth day of the month following the expiration date on the wallet card or the board office has been notified by another compact state that a licensee has declared a new primary state. Pursuant to 655—subrule 16.2(8), the former home state license shall no longer be valid upon the issuance of a new home state license.

a. If the inactive license is not reactivated, it shall remain inactive.

b. If the licensee resides in Iowa or a noncompact state, the licensee shall not practice nursing in Iowa until the license is reactivated to active status. If the licensee is identified as practicing nursing with an inactive license, disciplinary proceedings shall be initiated.

c. The licensee is not required to obtain continuing education credit or pay fees while the license is inactive.

d. To reactivate the license, the licensee shall complete the reactivation requirements.

(1) The licensee shall be provided an application, a continuing education report form, two fingerprint cards, a waiver form, and statement of the fees. The reactivation fee and criminal history background check fee are specified in the definition of “fees” in rule 655—3.1(17A,147,152,272C).

(2) The licensee shall have obtained 12 contact hours of continuing education, as specified in 655—Chapter 5, within the 12 months prior to reactivation.

(3) Upon receipt of the completed reactivation application, required continuing education materials, two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check, fees for both the reactivation and the criminal history background check and verification that the primary state of residence is Iowa or a noncompact state, the licensee shall be issued a license for a 24- to 36-month period. At the time of the next renewal, the license will be placed on a three-year renewal cycle. Expiration shall be on the fifteenth day of the licensee’s birth month. The board staff may issue a certificate of license prior to receipt of a report on the applicant from the DCI/FBI.

(4) An applicant who fails to complete the reactivation of licensure process within 12 months from the date of application must reapply. All fees are nonrefundable.

**3.7(6) *Duplicate wallet card or certificate.*** A duplicate wallet card or certificate shall be required if the current card or certificate is lost, stolen, destroyed or not received by the licensee within 60 days from the date the license is issued. The licensee shall be issued a duplicate wallet card or certificate upon receipt of an application for a duplicate wallet card or certificate and receipt of the fee as specified in rule 655—3.1(17A,147,152,272C). If the licensee notifies the board that the wallet card or certificate has not been received within 60 days after being issued, no fee shall be required. A fee is applicable when the licensee fails to notify the board of a name or address change.

**3.7(7) *Reissue of a certificate or wallet card.*** The board shall reissue a certificate or current wallet card upon receipt of a written request from the licensee, return of the original document and payment of the fee as specified in rule 655—3.1(17A,147,152,272C). No fee shall be required if an error was made by the board on the original document.

This rule is intended to implement Iowa Code sections 147.2 and 147.9 to 147.11.  
[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.8(17A,147,152,272C) Verification.** Upon written request from the licensee or another jurisdiction and payment of the verification fee as specified in rule 655—3.1(17A,147,152,272C), the board shall provide a certified statement to another jurisdiction or entity that the license of a registered nurse, licensed practical nurse or advanced registered nurse practitioner is active, inactive or encumbered/disciplined in Iowa.

This rule is intended to implement Iowa Code sections 147.2 and 147.8.  
[ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.9(17A,272C) License denial.**

**3.9(1)** Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that cites the factual and legal basis for denying the application, notifies the applicant of the appeal process and specifies the date upon which the denial will become final if not appealed.

**3.9(2)** An applicant who has been issued a preliminary notice of denial may appeal the notice and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director within 30 days following the date the preliminary notice of denial was mailed. The request for hearing shall specify the factual or legal errors in the preliminary notice of denial and provide any additional written information or documents in support of the licensure.

**3.9(3)** All hearings held pursuant to this rule shall be held in accordance with the process outlined in 655—Chapter 20.

**3.9(4)** If an applicant does not appeal a preliminary notice of denial, the preliminary notice of denial automatically becomes final and a notice of denial will be issued.

This rule is intended to implement Iowa Code chapters 17A and 272C.  
[ARC 7664B, IAB 3/25/09, effective 4/29/09; ARC 1815C, IAB 1/7/15, effective 2/11/15; ARC 2339C, IAB 1/6/16, effective 2/10/16]

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<sup>◇</sup> Two or more ARCs

<sup>1</sup> History relating also to “Licensure to Practice—Licensed Practical Nurse,” Ch 4 prior to IAC 5/23/84.

<sup>2</sup> Effective date of 11/9/88 delayed 70 days by the Administrative Rules Review Committee at its October meeting. Delay lifted by ARRC 11/16/88.



## CHAPTER 4 DISCIPLINE

[Prior to 5/23/84, IAC, "Disciplinary Proceedings" appeared as Ch 8]

[Prior to 5/23/84, "Licensure to Practice—Licensed Practical Nurse" appeared as Ch 4. See Ch 3.]

[Prior to 8/26/87, Nursing Board[590] Ch 4]

**655—4.1(17A,147,152,272C) Board authority.** The board of nursing may discipline a registered nurse, a licensed practical nurse or an advanced registered nurse practitioner for any grounds stated in Iowa Code chapters 147, 152,272C and 272D, or rules promulgated thereunder.  
[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—4.2(17A,147,152,272C) Complaints and investigations.** Complaints are allegations of wrongful acts or omissions relating to the ethical or professional conduct of a licensee.

**4.2(1)** In accordance with Iowa Code section 272C.3(1) "c," the board shall investigate or review, upon written complaint or upon its own motion pursuant to other information received by the board, alleged acts or omissions which the board reasonably believes constitute cause for licensee discipline.

**4.2(2)** The executive director, or an authorized designee, may review and investigate any complaint information received, in order to determine the probability that a violation of Iowa law or administrative rule has occurred.

**655—4.3(17A,147,152,272C) Issuance of investigatory subpoenas.** The board shall have the authority to issue an investigatory subpoena in accordance with the provisions of Iowa Code section 17A.13.

**4.3(1)** The executive director or designee may, upon the written request of a board investigator or on the executive director's own initiative, subpoena books, papers, records and other real evidence which are necessary for the board to decide whether to institute a contested case proceeding. In the case of a subpoena for mental health records, each of the following conditions shall be satisfied prior to the issuance of the subpoena:

- a. The nature of the complaint reasonably justifies the issuance of a subpoena;
- b. Adequate safeguards have been established to prevent unauthorized disclosure;
- c. An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and
- d. An attempt was made to notify the patient and to secure an authorization from the patient for release of the records at issue.

**4.3(2)** A written request for a subpoena or the executive director's written memorandum in support of the issuance of a subpoena shall contain the following:

- a. The name and address of the person to whom the subpoena will be directed;
- b. A specific description of the books, papers, records or other real evidence requested;
- c. An explanation of why the documents sought to be subpoenaed are necessary for the board to determine whether it should institute a contested case proceeding; and
- d. In the case of a subpoena request for mental health records, confirmation that the conditions described in subrule 4.3(1) have been satisfied.

**4.3(3)** Each subpoena shall contain the following:

- a. The name and address of the person to whom the subpoena is directed;
- b. A description of the books, papers, records or other real evidence requested;
- c. The date, time and location for production or inspection and copying;
- d. The time within which a motion to quash or modify the subpoena must be filed;
- e. The signature, address and telephone number of the executive director or designee;
- f. The date of issuance;
- g. A return of service.

**4.3(4)** Any person who is aggrieved or adversely affected by compliance with the subpoena and who desires to challenge the subpoena must, within 14 days after service of the subpoena, or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or

modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

**4.3(5)** Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to issue a decision or the board may issue a decision. Oral argument may be scheduled at the discretion of the board or the administrative law judge. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

**4.3(6)** A person aggrieved by a ruling of an administrative law judge who desires to challenge that ruling must appeal the ruling to the board by serving on the executive director, either in person or by certified mail, a notice of appeal within ten days after service of the decision of the administrative law judge.

**4.3(7)** If the person contesting the subpoena is not the person under investigation, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board's decision is not final for purposes of judicial review until either (1) the person is notified that the investigation has been concluded with no formal action, or (2) there is a final decision in the contested case.

**655—4.4(17A,147,152,272C) Board action.** The board shall review complaints and investigative materials and do one of the following:

**4.4(1)** Close the complaint case without action.

**4.4(2)** Request further inquiry, including peer review.

**4.4(3)** Issue a confidential letter of warning to the licensee. A letter of warning is not formal disciplinary action and is not a public document.

**4.4(4)** Determine the existence of sufficient probable cause and file a statement of charges or approve a combined statement of charges and settlement agreement.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—4.5(17A,147,152,272C) Peer review committee.** Any case may be referred to peer review for evaluation of the professional services rendered by the licensee.

**4.5(1)** The board shall enter into a contract with peer reviewers to provide peer review services. The board or board staff shall determine which peer reviewer(s) will review a case and what investigative information shall be referred to a peer reviewer.

**4.5(2)** Peer reviewers shall review the information provided by the board and provide a written report to the board. The written report shall contain an opinion of the peer reviewer regarding whether the licensee conformed to minimum standards of acceptable and prevailing practice of nursing and the rationale supporting the opinion.

**4.5(3)** Peer reviewers shall observe the confidentiality requirements imposed by Iowa Code section 272C.6(4).

**4.5(4)** The board shall review the committee's findings and proceed with action available under rule 655—4.4(17A,147,152,272C).

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—4.6(17A,147,152,272C) Grounds for discipline.** A licensee may be disciplined for failure to comply with the rules promulgated by the board and for any wrongful act or omission related to nursing practice, licensure or professional conduct.

**4.6(1)** In accordance with Iowa Code section 147.55(1), behavior which constitutes fraud in procuring a license may include, but need not be limited to, the following:

*a.* Falsification of the application, credentials, or records submitted to the board for licensure or license renewal as a registered nurse, licensed practical nurse, or advanced registered nurse practitioner.

*b.* Fraud, misrepresentation, or deceit in taking the licensing examination or in obtaining a license as a registered nurse, licensed practical nurse, or advanced registered nurse practitioner.

*c.* Impersonating any applicant in any examination for licensure as a registered nurse, licensed practical nurse, or advanced registered nurse practitioner.

**4.6(2)** In accordance with Iowa Code section 147.55(2), professional incompetency may include, but need not be limited to, the following:

- a.* Lack of knowledge, skill, or ability to discharge professional obligations within the scope of nursing practice.
- b.* Deviation by the licensee from the standards of learning, education, or skill ordinarily possessed and applied by other nurses in the state of Iowa acting in the same or similar circumstances.
- c.* Willful or repeated departure from or failure to conform to the minimum standards of acceptable and prevailing practice of nursing in the state of Iowa.
- d.* Willful or repeated failure to practice nursing with reasonable skill and safety.
- e.* Willful or repeated failure to practice within the scope of current licensure or level of preparation.
- f.* Failure to meet the standards as defined in 655—Chapter 6, Iowa Administrative Code.
- g.* Failure to meet the standards as defined in 655—Chapter 7, Iowa Administrative Code.
- h.* Failure to comply with the requirements of Iowa Code chapter 139A.

**4.6(3)** In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes knowingly making misleading, deceptive, untrue, or fraudulent representations in the practice of a profession may include, but need not be limited to, the following:

- a.* Oral or written misrepresentation relating to degrees, credentials, licensure status, records and applications.
- b.* Falsifying records related to nursing practice or knowingly permitting the use of falsified information in those records.

**4.6(4)** In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct or practice harmful or detrimental to the public may include, but need not be limited to, the following:

- a.* Performing nursing services beyond the authorized scope of practice for which the individual is licensed or prepared.
- b.* Allowing another person to use one's nursing license for any purpose.
- c.* Failing to comply with any rule promulgated by the board related to minimum standards of nursing.
- d.* Improper delegation of nursing services, functions, or responsibilities.
- e.* Committing an act or omission which may adversely affect the physical or psychosocial welfare of the patient or client.
- f.* Committing an act which causes physical, emotional, or financial injury to the patient or client.
- g.* Failing to report to, or leaving, a nursing assignment without properly notifying appropriate supervisory personnel and ensuring the safety and welfare of the patient or client.
- h.* Violating the confidentiality or privacy rights of the patient or client.
- i.* Discriminating against a patient or client because of age, sex, race, ethnicity, national origin, creed, illness, disability, sexual orientation or economic or social status.
- j.* Failing to assess, accurately document, evaluate, or report the status of a patient or client.
- k.* Misappropriating medications, property, supplies, or equipment of the patient, client, or agency.
- l.* Fraudulently or inappropriately using or permitting the use of prescription blanks, obtaining or attempting to obtain prescription medications under false pretenses, or assisting others to obtain or attempt to obtain prescription medication under false pretenses.
- m.* Practicing nursing while under the influence of alcohol, marijuana, or illicit drugs or while impaired by the use of legitimately prescribed pharmacological agents or medications.
- n.* Being involved in the unauthorized manufacture or distribution of a controlled substance.
- o.* Being involved in the unauthorized possession or use of a controlled substance.
- p.* Engaging in behavior that is contradictory to professional decorum.
- q.* Failing to report suspected wrongful acts or omissions committed by a licensee of the board.
- r.* Failing to comply with an order of the board.
- s.* For an advanced registered nurse practitioner, prescribing, dispensing, administering, or distributing drugs in an unsafe manner.

*t.* For an advanced registered nurse practitioner, prescribing, dispensing, administering or distributing drugs without accurately documenting it or without assessing, evaluating, or instructing the patient or client.

*u.* For an advanced registered nurse practitioner, prescribing, dispensing, administering or distributing drugs to individuals who are not patients or are outside the licensee's specialty area.

*v.* Engaging in repeated verbal or physical conduct which interferes with another health care worker's performance or creates an intimidating, hostile, or offensive work environment.

*w.* Failing to properly safeguard or secure medications.

*x.* Failing to properly document or perform medication wastage.

**4.6(5)** For purposes of this subrule, "patient" is defined to include the patient and the patient's family or caretakers who are present with the patient while the patient is under the care of the licensee. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct or practice harmful or detrimental to the public may include, but need not be limited to, the following professional boundaries violations:

*a.* Sexual contact with a patient, regardless of patient consent.

*b.* Making lewd, suggestive, demeaning, or otherwise sexual comments to a patient, regardless of patient consent.

*c.* Initiating, or attempting to initiate, a sexual, emotional, social, or business relationship with a patient, for personal gain, regardless of patient consent.

*d.* Soliciting, borrowing, or misappropriating money or property from a patient, regardless of patient consent.

*e.* Repeatedly divulging personal information to a patient for nontherapeutic purposes, regardless of patient consent.

*f.* Engaging in a sexual, emotional, social, or business relationship with a former patient when there is a risk of exploitation or harm to the patient, regardless of patient consent.

**4.6(6)** In accordance with Iowa Code section 147.55(4), habitual intoxication or addiction to the use of drugs may include, but need not be limited to, the following:

*a.* Excessive use of alcohol which may impair a licensee's ability to practice the profession with reasonable skill and safety.

*b.* Excessive use of drugs which may impair a licensee's ability to practice the profession with reasonable skill and safety.

**4.6(7)** In accordance with Iowa Code section 147.55(5), conviction of a crime related to the profession or occupation of the licensee or conviction of any crime that would affect the licensee's ability to practice within a profession means the following:

*a.* Pleading guilty to or being convicted of a crime related to the profession of nursing, or conviction of any crime that would affect the licensee's ability to practice nursing, regardless of whether the judgment of conviction or sentence was deferred, and regardless of the jurisdiction wherein the action occurred. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

*b.* Reserved.

**4.6(8)** In accordance with Iowa Code section 147.55(6), fraud in representation as to skill or ability.

**4.6(9)** In accordance with Iowa Code section 147.55(7), use of untruthful or improbable statements in advertisements.

**4.6(10)** In accordance with Iowa Code section 147.55(8), willful or repeated violations of provisions of Iowa Code chapter 147, 152, or 272C.

**4.6(11)** In accordance with Iowa Code section 147.55(9), other acts or offenses as specified by board rule, including the following:

*a.* Failing to provide written notification of a change of address to the board within 30 days of the event.

*b.* Failing to notify the board within 30 days from the date of the final decision in a disciplinary action taken by the licensing authority of another state, territory or country.

*c.* Failing to notify the board of a criminal conviction within 30 days of the action, regardless of whether the judgment of conviction or sentence was deferred, and regardless of the jurisdiction where it occurred.

*d.* Failing to submit an additional completed fingerprint packet as required and applicable fee, when a previous fingerprint submission has been determined to be unacceptable, within 30 days of a request made by board staff.

*e.* Failing to respond to the board during a board audit or submit verification of compliance with continuing education requirements or exceptions, within the time period provided.

*f.* Failing to respond to the board during a board audit or submit verification of compliance with training in child or dependent adult abuse identification and reporting or exceptions, within the time period provided.

*g.* Failing to respond to the board during a board audit or submit verification of compliance with the requirements for the supervision of fluoroscopy set forth in 655—subrule 7.2(2) or exceptions, within the time period provided.

*h.* Failing to respond to or comply with a board investigation or subpoena.

*i.* Engaging in behavior that is threatening or harassing to the board, board staff, or agents of the board.

*j.* Violating an initial agreement or contract with the Iowa nurse assistance program committee.

**4.6(12)** In accordance with Iowa Code section 147.2 or 147.10:

*a.* Engaging in the practice of nursing in Iowa prior to licensure or not pursuant to the nurse licensure compact.

*b.* Engaging in the practice of nursing in Iowa on an inactive license.

**4.6(13)** In accordance with Iowa Code section 152.10(2):

*a.* Continued practice while knowingly having an infectious or contagious disease which could be harmful to a patient's welfare, without taking precautions to meet the current standard of care.

*b.* Having a license to practice nursing as a registered nurse, licensed practical/vocational nurse or advanced registered nurse practitioner revoked or suspended or having other disciplinary action taken by a licensing authority of another state, territory, or country. A certified copy of the record or order of suspension, revocation, or disciplinary action is prima facie evidence of such fact. "Certified copy" means a complete and accurate copy of a document, as verified by the board or the agency providing that document. "Certified copy" includes an electronic version of a document provided to another agency or individual by the board, or received from another agency, so long as the electronic record is:

- (1) Obtained directly from the official Web site of the board or other agency;
- (2) Regularly updated by the board or the other agency in accordance with standard practice;
- (3) Accessible as a "read only" document;
- (4) Properly safeguarded to prevent the document from being altered; and
- (5) Certified from another agency in accordance with the laws applicable in that jurisdiction.

*c.* Having a license to practice nursing as a registered nurse, licensed practical/vocational nurse or advanced registered nurse practitioner revoked or suspended, or having other disciplinary action taken, by a licensing authority in another state which has adopted the nurse licensure compact contained in Iowa Code section 152E.1 or the advanced practice registered nurse compact contained in Iowa Code section 152E.3 and which has communicated information relating to such action pursuant to the coordinated licensure information system established by the compact. If the action taken by the licensing authority occurs in a jurisdiction which does not afford the procedural protections of Iowa Code chapter 17A, the licensee may object to the communicated information and shall be afforded the procedural protections of Iowa Code chapter 17A.

*d.* Knowingly aiding, assisting, procuring, advising, or allowing a person to unlawfully practice nursing.

*e.* Being adjudicated mentally incompetent by a court of competent jurisdiction. Such adjudication shall automatically suspend a license for the duration of the license unless the board orders otherwise.

*f.* Inability to practice nursing with reasonable skill and safety by reason of illness or as a result of a mental or physical condition.

[ARC 0084C, IAB 4/18/12, effective 5/23/12; ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—4.7(17A,147,152,272C) Sanctions.** A sanction is a disciplinary action by the board which resolves a contested case. The board may impose one or more of the following:

1. Revocation.
2. Suspension.
3. Restriction on engaging in specified procedures or acts.
4. Probation.
5. Order a physical, mental or substance abuse evaluation, alcohol or drug screening, or clinical competency evaluation.

6. Civil penalty. A fine may be imposed in accordance with Iowa Code section 272C.3(2) “e.” Assessment of a fine shall be specified in the order and may not exceed a maximum amount of \$1,000. Fines may be incurred for:

- Practicing without an active license: \$50 for each calendar month or part thereof, beginning on the date that a license enters inactive status.
  - Failing to respond to the board during a board audit or to submit verification of compliance with the continuing education requirements or exceptions: \$50 for each contact hour that is not verified.
  - Violating rule 655—4.6(17A,147,152,272C): an amount deemed appropriate.
7. Additional education, reexamination, or both.
  8. Citation and warning.
  9. Such other sanctions allowed by law as may be appropriate.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—4.8(17A,147,152,272C) Voluntary surrender.** A voluntary surrender of licensure may be submitted to the board as resolution of a contested case or in lieu of continued compliance with a disciplinary decision of the board. A voluntary surrender, when accepted by the board, has the same force and effect as an order of revocation.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

These rules are intended to implement Iowa Code chapter 17A and Iowa Code sections 147.55, 152.10, 272C.4, 272C.5, 272C.6, and 272C.9.

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CHAPTER 5  
CONTINUING EDUCATION  
[Prior to 8/26/87, Nursing Board[590] Ch 5]

**655—5.1(152) Definitions.**

*“Approved provider”* means those persons, organizations, or institutions that meet the criteria specified in subrule 5.3(2) and are authorized by the board to offer approved continuing education programs. Provider approval applies to all programs regardless of geographic location.

*“Approved provider number”* means the number assigned by the board which identifies an approved provider.

*“Audit”* means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period; or the selection of approved providers for verification of adherence to continuing education approved provider requirements during a specified time period.

*“Continuing education”* means planned, organized learning activities acquired following initial licensure and designed to maintain, improve, or expand nurses’ knowledge and skills or to develop new knowledge and skills relevant to nursing for the enhancement of practice, education, administration, or theory development to the end of improving the health of the public.

*“Criteria”* means those standards as defined in subrule 5.3(2) which the provider shall meet to be an approved provider.

*“Extended course”* means an organized program of study offered in a series of sessions.

*“Formal offering”* means an extension course, independent study, or other course which is offered for academic credit or audit by an accredited institution of higher education. A formal offering need not be offered by an approved provider.

*“Informal offering”* means workshop, seminar, institute, conference, lecture, extended course, provider designed self-study, or learner designed self-study which is offered for credit in contact hours or continuing education units.

*“In-service”* means activities intended to assist nurses to acquire, maintain, or expand nurses’ knowledge and skills in fulfilling the assigned responsibilities specific to the expectations of the employer.

*“Learner designed self-study”* means the learner takes the initiative and the responsibility for assessing, planning, implementing, and evaluating an educational activity under the guidance of an approved provider. The provider may award credit to a nurse for learner designed self-study such as lecture development, research, preparation of articles for publication, development of patient care or patient education programs, or projects directed at resolving administrative problems.

*“Nonapproved provider”* means those persons, organizations, or institutions who do not hold an Iowa approved provider number. The board may recognize credit from nonapproved providers under special situations as specified in subrule 5.2(2), paragraph “f,” subparagraphs (2) and (3).

*“Practicum”* means a course-related, planned and supervised clinical experience which includes clinical objectives and assignment to practice in a laboratory setting or with patients/clients/families for attainment of the objectives.

*“Provider designed self-study”* means that the provider designs a program for learning for the nurse who completes the program at the individual’s pace, e.g., home study, programmed instruction.

**655—5.2(152) Continuing education — licensees.**

**5.2(1) Board authority.** The board derives its authority under Iowa Code chapter 272C to create continuing education requirements as a prerequisite to obtain a current license and an audit system to ensure compliance. Rules relating to the continuing education and licensing of registered nurses and licensed practical nurses are found in this chapter; rules relating to the continuing education and licensing of advanced registered nurse practitioners are found in nursing board rules, 655—Chapter 7.

**5.2(2) Requirements.** To obtain a registered nurse or licensed practical nurse license for the next renewal period, the licensee shall verify the completion of continuing education requirements or exceptions to the requirements, as outlined in subrule 5.2(3).

*a.* Thirty-six contact hours or 3.6 continuing education units (CEUs) shall be required for renewal of a three-year license. Twenty-four contact hours or 2.4 CEUs shall be required for renewal of a license which was issued for less than three years as a result of one of the following:

- (1) Examination.
- (2) Endorsement into Iowa from another state.
- (3) Reactivation from inactive status.

*b.* The hours specified in paragraph “*a*” shall be completed in the license period for which the license was issued. Credit will not be accepted for a duplication of informal or formal offerings within a license period.

*c.* Continuing education credits from a previous license period including all make-up credit shall not be used, nor shall credits be accumulated for use in a future licensure period.

*d.* Units of measurement used for continuing education courses shall be as follows:

(1) 1 contact hour = 50 minutes of didactic instruction, work on learner designed self-study, and clinical or laboratory practicum in an informal offering.

(2) 1 CEU = 10 contact hours of instruction.

(3) 1 academic semester hour = 15 contact hours of instruction.

(4) 1 academic quarter hour = 10 contact hours of instruction.

*e.* To be approved for continuing education credit, formal offerings shall meet the qualifications of appropriate subject matter as specified in subrule 5.3(2), paragraph “*a*,” or be required toward meeting the requirements of a nursing education program which extends beyond the education completed for the original nursing license. Questions about whether particular formal offerings will be approved may be directed to the board office. A denial of approval may be appealed to the board within one month of the denial. The licensee shall retain a transcript exhibiting a passing grade for each formal offering or verification of attendance for offerings which are audited.

*f.* To be approved for continuing education credit, informal offerings shall meet the qualifications of appropriate subject matter as specified in subrule 5.3(2), paragraph “*a*.” There are no restrictions on amount of credit acquired through learner designed or provider designed self-study. The licensee shall retain a certificate to verify completion of each informal offering.

(1) Informal offerings shall be accepted when offered by board-approved providers or when guided by board-approved providers in learner designed self-study. All learner designed self-study and all offerings within Iowa including distance education technology, e.g., satellite programming, shall be sponsored by a board-approved provider to be acceptable.

(2) Informal offerings attended outside of Iowa or offered as self-study, including Internet self-study, shall be accepted when recognized by other state boards of nursing with mandatory continuing education requirements or offered by the American Nurses’ Association, National League for Nursing, National Federation of Licensed Practical Nurses, National Association for Practical Nurse Education and Service, Inc. These informal offerings shall be in accordance with the continuing education standards as follows:

1. American Nurses’ Credentialing Center Manual for Accreditation as a Provider of Continuing Education in Nursing in effect in 2001 and the Manual for Accreditation as an Approver of Continuing Education in effect in 2001.

2. National League for Nursing criteria and guidelines of the International Association for Continuing Education and Training in effect in 2000.

3. National Federation of Licensed Practical Nurses Continuing Education Department policies and procedures in effect in 1997.

4. National Association for Practical Nurse Education and Service, Inc. (NAPNES) Criteria for Approval of Continuing Education in effect in 2000.

(3) Informal offerings offered from nonapproved providers outside of Iowa or an organization not specified in subrule 5.2(2), paragraph “*f*,” subparagraph (2), whether it be a self-study course,

an Internet self-study course, or a live presentation attended outside of Iowa, shall be accepted when specially approved by the board for an individual licensee. A licensee shall obtain special approval from the board office in order to receive credit acceptable to fulfill the requirements. The special approval application form is available from the board office upon request. Special approval requires submission of a completed application and a brochure, advertisement, or course description prior to the completion of the licensure period. Course content shall meet the qualifications of appropriate subject matter as specified in subrule 5.3(2), paragraph "a." The licensee shall retain the approval letter from the board office, in addition to the certificate of attendance received from the nonapproved provider. A denial of approval may be appealed to the board within one month of the denial.

g. Activities not specified in subrule 5.2(2), paragraph "e" or "f," shall be considered appropriate for continuing education credit only after approval has been obtained in writing from the board.

**5.2(3) Exceptions to the requirements in subrule 5.2(2), paragraph "a."** A waiver of continuing education requirements or extensions of time within which to fulfill the requirements may be granted on an individual basis. Specific instructions are available from the board office for the following:

a. A licensee shall be deemed to have complied with the continuing education requirements during periods that person serves honorably on active duty in the military service as specified in Iowa Code section 272C.2(3). The continuing education credit requirements shall be waived; however, a licensee who claims this exception shall retain evidence of active duty to be presented upon request from the board.

(1) A licensee who served on active duty for the entire license period or through the end of the license period shall be exempt from the requirement of continuing education credits.

(2) A licensee who served on active duty for a portion of a license period but is not on active duty at the time of renewal shall comply with continuing education requirements of Iowa for the remainder of the license period. The required hours are prorated at 12 contact hours per year for each period of 12 consecutive months when not on active duty.

b. A licensee shall be deemed to have complied with the continuing education requirements when that person, at the time of renewal, resides outside of Iowa and holds a current license to practice in a state other than Iowa which also has mandatory continuing education. The continuing education credit requirements shall be waived; however, a licensee who claims this exception shall retain evidence of the out-of-state license to be presented upon request from the board.

(1) A licensee who resides out of state for the entire license period or through the end of the license period and meets a state's continuing education requirements to maintain a current license shall be exempt from the requirements of continuing education credits.

(2) A licensee who resided out of state for a portion of a license period but is residing in Iowa at the time of renewal shall comply with continuing education requirements of Iowa for the remainder of the license period. The required hours are prorated at 12 contact hours per year for each period of 12 consecutive months of residence in Iowa.

c. A licensee shall be deemed to have complied with the continuing education requirements during periods that person is a government employee working as a registered nurse or licensed practical nurse and assigned to duty outside of the United States as specified in Iowa Code section 272C.2(4). The continuing education credit requirement shall be waived; however, a licensee who claims this exception shall retain evidence of government employment outside the United States to be presented upon request from the board.

(1) A licensee who is a government employee serving outside the United States for the entire license period or through the end of the license period shall be exempt from the requirement of continuing education credits.

(2) A licensee who is a government employee serving outside the United States for a portion of a license period, but is not in that status at the time of renewal, shall comply with continuing education requirements of Iowa for the remainder of the license period. The required hours are prorated at 12 contact hours per year for each period of 12 consecutive months when not in that status.

d. A licensee shall be deemed to have complied with the continuing education requirements during periods that person is in foreign service as a registered nurse or licensed practical nurse outside the United

States where a current license is required. The continuing education credit requirement shall be waived; however, a licensee who claims this exception shall retain evidence of foreign service requiring licensure to be presented upon request from the board.

(1) A licensee who is serving in such a position for the entire license period or through the end of the license period shall be exempt from the requirement for continuing education credits.

(2) A licensee who is serving in such a position for a portion of the license period, but is not in that status at the time of renewal, shall comply with continuing education requirements of Iowa for the remainder of the license period. The required hours are prorated at 12 contact hours per year for each period of 12 consecutive months when not in that status.

*e.* A licensee shall be deemed to have complied with the continuing education requirements when that person at the time of renewal possesses evidence of certification in a specialty area of nursing practice for the advanced registered nurse practitioner as defined in rule 655—7.1(152). The continuing education credit requirements shall be waived; however, a licensee who claims this exception shall retain evidence of current certification by the national organization to be submitted upon request.

*f.* A licensee who has had a physical or mental disability or illness during the license period shall be eligible for a waiver. A waiver provides for an extension of time or exemption from some or all of the continuing education requirements. An application for a waiver is available upon request to the board office. The application requires the signature of a physician who can attest to the existence of a disability or illness during the license period. The application for a waiver shall be approved or denied depending on the disability or illness of the licensee. A licensee shall be notified of the decision. A licensee who obtains approval shall retain a copy of the waiver to be presented to the board upon request.

**5.2(4)** *Failure to meet requirements or conditions for exceptions to requirements.* The licensee who fails to meet the requirements or the conditions for exceptions has the following options:

*a.* If the requirements or the conditions for exceptions are met during the late renewal period, as defined in rule 655—3.1(17A,147,152,272C), the licensee may retain the license in an active status.

(1) To remain active, the licensee shall complete the continuing education requirements as specified in subrule 5.2(2) or 5.2(3) as well as other requirements specified in 655—subrule 3.7(4). The licensee shall be required to submit to an audit of continuing education following the late renewal. The licensee shall automatically be reaudited when late credit has been accepted.

(2) Failure to renew within 30 days after expiration shall cause the license to be placed on inactive status.

*b.* An inactive license as defined in rule 655—3.1(17A,147,152,272C) may be reactivated.

*c.* To reactivate a license, the licensee shall obtain 12 contact hours of continuing education within the 12 months prior to reactivation and complete the requirements specified in 655—subrule 3.7(5).

**5.2(5)** *Audit of licensees.* The board may select licensees for audit following a period of licensure.

*a.* The licensee must submit verification of compliance with continuing education requirements or exceptions for the period of licensure being audited. Verification for satisfactory completion of the audit includes legible copies of certificates of attendance, transcripts, special approval of informal offerings from nonapproved providers, or documentation of compliance with exceptions in subrule 5.2(3).

*b.* The licensee must submit verification of the requirement specified in 655—subrule 3.7(3).

*c.* Verification must be submitted within one month after the date of the audit. Extension of time may be granted on an individual basis.

*d.* If submitted materials are incomplete or unsatisfactory, the licensee shall be notified. The licensee shall be given the opportunity to submit make-up credit to cover the deficit found through the audit. The deadline for receipt of the documentation for this make-up credit is within 90 days of receipt of the board office notification. The licensee shall be reaudited during the next renewal period when make-up credit has been accepted.

*e.* Licensees are required to keep certificates of attendance, letters verifying special approval for informal offerings from nonapproved providers, transcripts, and documentation of compliance with exceptions for four years.

*f.* The board shall notify the licensee of satisfactory completion of the audit.

g. Failure to complete the audit satisfactorily or falsification of information shall result in board action as described in nursing board rules, 655—Chapter 4.

h. Failure to notify the board of a current mailing address will not absolve the licensee from the audit requirement; completion of an audit will be required prior to further license renewal.

**655—5.3(152) Continuing education — providers.**

**5.3(1) Board authority.** The board derives its authority under Iowa Code chapter 272C to create requirements for becoming an approved provider and maintaining that status. The board also has the authority to develop an audit, a mechanism to verify compliance with criteria for approved providers.

**5.3(2) Criteria for approved providers.** The approved providers shall show evidence of capability to adhere to criteria indicative of quality continuing education activities for nurses.

a. Criteria related to appropriate subject matter. Appropriate subject matter for continuing education credits reflects the educational needs of the nurse learner and the health needs of the consumer. Subject matter is limited to offerings that are scientifically founded and predominantly for professional growth. The following areas are deemed appropriate subject matter for continuing education credit:

- (1) Nursing practice related to health care of patients/clients/families in any setting.
- (2) Professional growth and development related to nursing practice roles and designed to enhance the delivery of patient care and health service.
- (3) Sciences upon which nursing practice, nursing education, or nursing research is based, e.g., nursing theories and biological, physical, behavioral, computer, social, or basic sciences.

- (4) Social, economic, ethical and legal aspects of health care.

- (5) Management or administration of health care, health care personnel, or health care facilities.

- (6) Education of patients or their significant others, students, or personnel in the health care field.

b. Criteria related to operation of an approved continuing education providership. The provider shall:

- (1) Have a consistent, identifiable authority who has overall responsibility for the operation of the providership and execution of the informal offerings who is knowledgeable in administration and has the capability to organize, execute, and evaluate the overall operations of the providership.

- (2) Have an organizational chart to delineate lines of authority and communication within the providership as well as within the parent organization, if applicable, and other cooperative or advisory committees.

- (3) Develop and implement a philosophy, goals and objectives consistent with the controlling institution, if applicable, which reflect the provider beliefs about nursing, education, and continuing education. These shall indicate the overall direction of the providership for a five-year period.

- (4) Maintain financial integrity so that participants receive the continuing education for which they have paid.

- (5) Maintain participant and program records as specified in paragraph “c” of this subrule.

- (6) Demonstrate active nursing participation in the planning and administration of informal offerings. Nursing participation shall be documented in a written statement of policy, denotation on the organizational chart, and planning minutes.

- (7) Select appropriate subject matter designed to fulfill the educational needs of nurses in order to meet the health care needs of consumers. Have a subject matter plan which indicates the mechanism of assessing the learning needs of the population to be served and describes how the provider shall meet the appropriate subject matter criteria as specified in subrule 5.3(2), paragraph “a,” subparagraphs (1) to (6).

- (8) Demonstrate planning for each offering that includes a statement of purpose and measurable, educational objectives.

- (9) Provide notification to licensees of the availability of informal offerings. A brochure or written advertisement shall be developed for all informal offerings other than learner designed self-study and a copy shall be sent to the board prior to each offering. The brochure or advertising shall accurately describe the activities by including the date, time, location, statement of purpose, educational objectives, intended audience, credentials of instructors, amount of continuing education credit to be awarded, and,

if applicable, costs and items covered by the fee and refund policy. The board-approved provider number shall appear on the brochure or written advertisement.

(10) Structure program content and learning experience to relate to the stated purpose and objectives. Program content shall cover one topic or a group of closely related topics. Current, relevant, scientifically based supportive materials shall be used.

(11) Develop policies and procedures for verification of satisfactory completion of the activity by each participant including a system for verification of satisfactory completion, the control methods to ensure completion and a method to inform participants that completion of the offering is required prior to the award of credit. The provider shall not require exchanging an evaluation form for a certificate of completion. The provider may award credit to other members of the providership who attend but do not serve as organizers during the actual offering. The provider may make an exception and award partial credit in extreme emergency conditions. The provider may make an exception and award credit for the portion of time the speaker attended the offering excluding the presentation time; however, full credit may be awarded to a speaker who presents the offering for the first time. The provider may base the verification of satisfactory completion of an extended course on the participant's meeting the course objectives rather than on the number of sessions attended.

(12) Develop policies and procedures for management of continuing education programs including registration procedures, tuition refund, and enrollee grievances.

(13) Assign credit according to a uniform measure of credit as defined in subrule 5.2(2), paragraph "d." No credit shall be awarded for less than one contact hour or .1 CEU.

(14) If desired, cosponsor an offering provided by a nonapproved provider. When cosponsoring is done, the approved provider is responsible for assurance that all criteria in subrule 5.3(2) are met. A cosponsorship contract or letter of agreement shall delineate responsibilities of all parties, which includes the approved provider awarding the credit and maintaining the program and participant records. Cosponsoring is not acceptable for learner designed self-study.

(15) An approved provider shall notify the board within 30 days of changes in the administrative authority or address of the providership or the inability to meet the criteria.

c. Criteria related to record system and maintenance of continuing education programs. The provider shall:

(1) Maintain participant records for a minimum of four years from the date of program completion. The participant records shall include the name of licensee, license number, contact hours or CEUs awarded, offering titles, and dates of offerings. The record system shall provide for secure storage and retrieval of the participant records of continuing education. Secure storage shall include limiting employee access and describing security measures. Individual attendance and information regarding each offering shall be available within two weeks upon request from individual nurses or the board. If individual nurses are assessed a fee for this retrieval service, the fee shall be specified.

(2) Maintain program records for a minimum of four years from the date of program completion.

Program records for all informal offerings, other than learner designed self-study, shall include a brochure or advertising, roster of participants to whom credit was awarded, and a summary of the program including participant and provider evaluations. The provider shall maintain records for one informal offering which includes all required materials for renewal for approved providers as specified in subrule 5.3(4), paragraph "a," subparagraph (6).

Program records for learner designed self-study shall include the written agreement between the learner and provider, date of completion, and learner and provider evaluations.

(3) Furnish a certificate to each participant documenting the date the credit was earned. The front of the certificate shall display: participant's name, provider number, contact hours or continuing education units awarded, dates of the offering, subject matter taken, and a reminder to the participant to retain the certificate for four years. A certificate issued by electronic means must be a print-only file.

d. Criteria related to faculty of informal offerings. The faculty shall:

(1) Be current, knowledgeable, and skillful in the subject matter of the offering by having evidence of further education in the subject. Such education shall be acquired through course completion or an advance degree, experience in teaching in the specialized area within the three years preceding the

offering, or six months' work experience in the specialized area within the three years preceding the offering.

(2) If applicable, be skillful in assisting a nurse in designing a learner designed self-study program by having experience or education in course design.

(3) Include a nurse if the subject matter is nursing or if it is learner designed self-study.

(4) Encourage active participation of the nurse learners enrolled in the offerings.

(5) Utilize principles of adult education in teaching strategies.

(6) Utilize teaching methodologies appropriate to the subject, audience, and time allotment.

(7) Utilize current supportive materials by drawing from resources that are predominantly less than five years old unless the topic is of an historical nature.

(8) Not receive credit when teaching participants; however, an exception may be made as specified in subrule 5.3(2), paragraph "b," subparagraph (11).

(9) Not receive credit for learner designed self-study from a provider which employs them in the regular administration of the providership.

*e.* Criteria related to evaluation of continuing education programs. The provider shall include:

(1) A design for participants to assess achievement of program objectives, faculty effectiveness, and teaching-learning methodologies, resources and facilities for each offering.

(2) Evaluation techniques to assess the effectiveness of each offering and plan for future offerings.

(3) A method of notifying the participants that the evaluation may be submitted directly to the board.

*f.* Additional criteria related to management of learner designed self-study for providers who wish to guide this type of education. The provider shall:

(1) Provide a written application process through which the learner describes the following:

Individual's assessed need for the learning activity which meets the criteria related to appropriate subject matter found in this subrule, paragraph "a."

Purpose for pursuing the learning activity.

Objectives clarifying the purpose and providing a description of expected learning outcomes in measurable, behavioral terms.

Learning experiences or activities detailed in a plan for achieving the behavioral objectives.

Learning resources identifying people, materials, and facilities to be utilized to achieve the purpose and objectives.

Timetable for completion of learning activities.

Method of evaluation to be used which ensures completion of the learning activities, the objectives, and the number of hours required.

(2) Provide a written agreement with the learner. The written agreement shall include:

The approved written application.

Cost and refund policy.

Number of contact hours to be awarded.

The board-approved provider number.

Signatures of the nurse learner and the faculty managing this learner designed self-study.

Date of the agreement.

(3) Provide an evaluation which indicates successful completion of the terms of the written agreement and the award of a certificate of completion.

**5.3(3) Initial approval process for providers.** Initial approval is granted upon the submission of required materials and the determination by the board or its representative that the materials fulfill the criteria for approved providers specified in subrule 5.3(2).

*a.* Upon request, the board office shall send an application to a potential provider which requires the submission of the following materials:

(1) Designation of the administrative authority and biographical information about the administrative authority.

(2) Organizational chart.

(3) Philosophy, goals and objectives.

- (4) List of program offerings.
- (5) Evidence of nursing participation.
- (6) Plan on subject matter.
- (7) A policy for record system and maintenance.

A policy regarding the certificate and a sample of the certificate to be used.

A sample of a written agreement for learner designed self-study, if applicable.

- (8) Policies and procedures for verification of satisfactory completion of an offering.

- (9) A policy for registration procedures and tuition refund.

- (10) A policy for the written advertisement.

- (11) A policy regarding enrollee grievances.

- (12) A policy regarding participant and provider evaluation.

- (13) A policy regarding faculty selection.

- (14) A policy regarding the use of the uniform measure of continuing education credit.

- (15) Documents from a typical sample course offering. Documents for this offering shall include:

A narrative of the planning of the offering including evidence of nursing participation.

A sample brochure or advertising.

Content of course, e.g., topical outline.

Teaching-learning methodologies and supportive materials.

Bibliography.

A sample evaluation form for participant completion.

A sample evaluation form for provider completion.

- (16) A policy for cosponsorship of offerings, if applicable, and a sample contract or letter of agreement.

*b.* Upon receipt of the completed application and two copies, a review is held by a committee.

- (1) The committee is composed of at least three appointees of the board. The review is held at the board office within 60 days of receipt of the application.

- (2) The review is based on the criteria as specified in subrule 5.3(2).

- (3) If the submitted materials meet the requirements, the committee shall approve the provider for five years and issue a provider number. The approved provider shall be notified of the decision within two weeks of the committee review.

- (4) If the committee finds submitted materials to be incomplete or unsatisfactory, it shall notify the provider applicant of the decision within two weeks of the committee review. The applicant is given the opportunity to meet the criteria with an additional review to be held within six weeks of receipt of the revised application materials at the board office.

- (5) If the applicant is unable to meet the criteria within three committee reviews or one year from the receipt of the initial application at the board office, whichever comes first, the committee shall recommend nonapproval at the next regularly scheduled board meeting.

- (6) Notice of this recommendation of nonapproval shall be provided to the applicant at least 30 days before the board meeting.

- (7) The board shall make the final decision.

*c.* At any time the provider applicant disagrees with the committee's actions, the applicant may request board action. At this time the matter becomes a contested case and an evidentiary hearing as specified in Iowa Code chapter 17A shall be held by the board at its next regularly scheduled meeting.

- (1) If the final decision of the board is approval, approval shall be granted up to five years and an approved provider number is issued. The applicant shall be notified of the decision within two weeks of the board's final decision.

- (2) If the final decision of the board is a denial, the applicant shall be notified of the decision within two weeks of the board's final decision. Provisions for making a request for reconsideration and appeal are found in Iowa Code sections 17A.16 and 17A.19.

*d.* A provider applicant who has been denied approved provider status may apply no sooner than one year after denial to become an approved provider by starting the initial approval process specified in this subrule.

**5.3(4) *Reapproval process for approved providers.*** Reapproval is granted upon the submission of required materials and the determination by the board or its representatives that the materials fulfill the criteria for approved providers specified in this chapter.

*a.* The board shall send an application for reapproval to an approved provider six months before the expiration of the current approval. The completed application shall be submitted to the board office no later than three months prior to the expiration of the current approval. The application requires submission of the following materials:

(1) Identification of the current administrative authority. The information shall include the name(s) and title(s) of the authority.

(2) Current table of organization. The table shall:

Delineate the administrative authority for the providership.

Define the line relationships within the providership as well as within the parent organization, if applicable.

Illustrate cooperative or advisory relationships, if applicable.

(3) Goals, philosophy, and objectives. These shall:

Be described in regard to accomplishments, strengths, and weaknesses during the approval period.

Indicate the overall direction of the providership for the next five-year period, taking into consideration the strengths and weaknesses of the providership.

(4) List of course offerings from the previous year.

(5) Explanation of changes. A new policy or procedure shall be submitted for each change made since the previous approval.

(6) Documents from a typical course offering. The following documents shall be included:

A narrative of the planning of the offering.

A brochure, advertising, or written agreement.

Content of course, e.g., topical outline.

Teaching-learning methodologies and supportive materials.

Bibliography.

Attendance record.

Participant evaluation form.

Summary of participant and provider evaluations.

A sample of the current participant evaluation form and certificate.

*b.* Upon receipt of the application for reapproval, a review shall be made by a board designee at the board office within 30 days of receipt of the application.

(1) The review is based on the criteria as specified in subrule 5.3(2).

(2) If the submitted materials meet the requirements, the designee shall issue a renewal of the approved provider status for a five-year period.

(3) If the submitted materials are incomplete or unsatisfactory, the designee shall notify the provider of the decision within two weeks of the committee review. The provider shall be given the opportunity to meet the criteria within 30 days of the receipt of the board office notification. If the provider is unable to meet the requirements, the designee shall recommend nonapproval at the next regularly scheduled board meeting.

(4) Notice of this recommendation of nonapproval shall be provided to the applicant at least 30 days before the board meeting.

(5) The board shall make the final decision.

(6) At any time the renewal applicant disagrees with the designee's actions, the applicant may request board action. At this time the matter becomes a contested case and an evidentiary hearing as specified in Iowa Code chapter 17A shall be held by the board at its next regularly scheduled meeting, when the board shall issue a final decision.

(7) If the final decision of the board is reapproval, approval shall be granted up to five years. The approved provider shall be notified of the decision within two weeks of the board's final decision.

(8) If the final decision of the board is denial, the reapproval applicant shall be notified of the decision within two weeks of the board's decision. Provisions for making a request for reconsideration and appeal are found in Iowa Code sections 17A.16 and 17A.19.

(9) A reapproval applicant who has been denied reapproval may apply no sooner than one year after denial to become an approved provider by starting the initial approval process specified in subrule 5.3(3).

**5.3(5) *Audit of approved providers.*** The board shall monitor approved providers for adherence to criteria as established in this chapter.

*a.* The board may order an audit of an approved provider or may audit as a result of a written complaint. A written complaint may be filed with the board against a provider for acts or omissions which indicate a failure to meet the criteria established in this chapter. If the complaint is in regard to a particular offering, it shall be filed within one month of the completion of the offering.

*b.* The board may revoke the approved provider status for willful or repeated failure to meet one or more of the criteria specified in subrule 5.3(2).

*c.* A notice of revocation shall be issued to the provider. The provider will have 30 days to request a hearing for reconsideration of revocation. If a request for hearing is not received within the 30 days, the revocation shall be considered final.

*d.* The hearing will be conducted by the board pursuant to 655—20.1(17A,147,152,272C).

*e.* A provider who wishes to request rehearing shall do so within 20 days from the date of receipt of decision. The provider shall submit a statement which shows cause why action should not have been taken by the board. This statement shall be acted upon by the board within 20 days.

*f.* A provider who wishes to appeal the sanction imposed by the board may do so pursuant to Iowa Code section 17A.19.

*g.* A provider whose approved provider status has been revoked shall no longer advertise that it is an approved provider. The provider number shall no longer be used or appear in brochures, advertisements, certificates, or other materials.

*h.* A provider whose approved provider status has been revoked shall maintain the records required in subrule 5.3(2) until four years after the last credit was granted or transfer the records to the custody of the board.

*i.* The board shall notify other states which have mandatory nursing continuing education of the revocation of the approved provider status and the reason(s) for withdrawal.

*j.* A provider whose approved provider status has been revoked may apply no sooner than one year after the withdrawal of approval to become an approved provider by the initial approval process described in subrule 5.3(3).

**5.3(6) *Voluntary relinquishment of an approved providership.*** An approved provider may voluntarily relinquish its provider number. If an approved provider does not submit the required materials for reapproval or is unable to be located by the board, by certified mail, the board will consider that the provider voluntarily relinquished its approved provider status effective with the return of the certified mail or as determined by the executive director. When the approved providership has been voluntarily relinquished, the provider shall discontinue providing continuing education that is acceptable for license renewal in Iowa.

*a.* The provider shall maintain the records subrule required in 5.3(2) until four years after the last credit was granted or transfer the records to the custody of the board.

*b.* The board shall notify other states which have mandatory nursing continuing education of the relinquishment of the approved provider status and the reason(s) for relinquishment.

*c.* The provider whose approved provider status has been voluntarily relinquished may apply to become an approved provider by starting the initial approval process specified in subrule 5.3(3).

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

These rules are intended to implement Iowa Code sections 272C.2 and 272C.3.

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[Filed ARC 2339C (Notice ARC 2109C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]



CHAPTER 9  
DECLARATORY ORDERS

The board of nursing hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to declaratory orders which are printed in the first volume of the Iowa Administrative Code.

**655—9.1(17A) Petition for declaratory order.** In lieu of the words “(designate agency)”, insert “board of nursing”.

In lieu of the words “(designate office)”, insert “Iowa Board of Nursing, RiverPoint Business Park, 400 S.W. Eighth Street, Suite B, Des Moines, Iowa 50309-4685”.

In lieu of the words “(AGENCY NAME)”, insert “BOARD OF NURSING”.

Delete the following: “(An agency may wish to describe here a simplified alternative petition form that would be more appropriate for some members of its clientele in light of their particular circumstances.)”.

**655—9.2(17A) Notice of petition.** In lieu of the underline insert “15” and delete the words “(15 or less)”.

In lieu of the words “(designate agency)”, insert “board of nursing”.

**655—9.3(17A) Intervention.**

**9.3(1)** In lieu of the underline, insert “15”.

**9.3(2)** In lieu of the words “(designate agency)”, insert “board of nursing”.

**9.3(3)** In lieu of the words “(designate office)”, insert “the board of nursing”.

In lieu of the words “(designate agency)”, insert “board of nursing”.

In lieu of the words “(AGENCY NAME)”, insert “BOARD OF NURSING”.

Delete the words “(An agency may wish to describe here a simplified alternative petition for intervention form that would be more appropriate for some members of its clientele in light of their particular circumstances.)”.

**655—9.4(17A) Briefs.** In lieu of the words “(designate agency)”, insert “board of nursing”.

**655—9.5(17A) Inquiries.** In lieu of the words “(designate official by full title and address)”, insert “the Executive Director, Iowa Board of Nursing, RiverPoint Business Park, 400 S.W. Eighth Street, Suite B, Des Moines, Iowa 50309-4685”.

**655—9.6(17A) Service and filing of petitions and other papers.**

**9.6(2)** In lieu of the words “(specify office and address)”, insert “Iowa Board of Nursing, RiverPoint Business Park, 400 S.W. Eighth Street, Suite B, Des Moines, Iowa 50309-4685”.

In lieu of the words “(agency name)”, insert “board of nursing”.

**9.6(3)** In lieu of the words “(uniform rule on contested cases X.12(17A))”, insert “655 IAC 20.17(17A)”.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—9.7(17A) Consideration.** In lieu of the words “(designate agency)”, insert “board of nursing”.

**655—9.8(17A) Action on petition.**

**9.8(1)** In lieu of the words “(designate agency head)”, insert “board of nursing”.

**9.8(2)** In lieu of the words “as defined in (contested case uniform rule X.2(17A))”, insert “the date of mailing of a decision or order, or date of delivery if service is by other means, unless another date is specified”.

**655—9.9(17A) Refusal to issue order.**

**9.9(1)** In lieu of the words “(designate agency)”, insert “board of nursing”.

2. In lieu of the words “(designate agency)”, insert “board of nursing”.
3. In lieu of the words “(designate agency)”, insert “board of nursing”.
10. In lieu of the words “(designate agency)”, insert “board of nursing”.

Delete the words “(Where the agency’s experience enables it to define in advance other specific reasons for refusing to issue a declaratory ruling, it should include them here.)”.

**655—9.12(17A) Effect of a declaratory order.** In lieu of the words “(designate agency)”, insert “board of nursing”.

[Filed 2/17/88, Notice 8/26/87—published 3/9/88, effective 4/13/88]

[Filed 4/29/99, Notice 3/24/99—published 5/19/99, effective 7/1/99]

[Filed ARC 2339C (Notice ARC 2109C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]

CHAPTER 11  
EXAMINATION OF PUBLIC RECORDS

**655—11.1(17A,22,147,152,272C) Definitions.**

“*Access to records*” means the general right of the public to examine and copy records. In subrule 11.2(9), it also means the right of the subject of a confidential record to authorize its release, in writing, to a named third party.

“*Confidential record*” means a record which is not available to members of the public except as specified in Iowa Code section 22.7 or other law forbidding disclosure. Nothing in this definition shall be construed to deny access to the public portions of a record which contains a mixture of public and confidential information, or to broaden the definition of confidential information to include an entire document.

“*Custodian of records*” means the executive director of the board or that official’s designee.

“*Disclosure*” means the availability or release of a record.

“*Individual*” means a living person. It does not include persons such as sole proprietorships, partnerships, corporations, or educational institutions. A business firm which is identified by the name of one or more persons is not an individual within the meaning of this part.

“*Open records*” are those records which are not authorized or required to be kept confidential under Iowa Code section 22.7 or any other provision of the law.

“*Personally identifiable information*” means information about or pertaining to an individual in a record which identifies the person by personal identifier such as the name of the individual, number, symbol or other unique retriever assigned to the individual and which is contained in a system of records as defined in this subrule.

“*Record,*” when used in these rules means “public record,” includes all records, documents, tapes or other information stored or preserved in any medium of or belonging to the board.

“*Release of information*” means granting access to examine records and providing copies as requested.

“*Subject of a record*” means an individual under whose name or other personal identifier a record is kept in a system of records.

“*System of records*” means any group of records under the control of the board from which a record is retrieved by personal identifier and all records or group of records that are not retrievable by personal identifier. Papers maintained by individual employees of the board which are prepared, maintained, or discarded at the discretion of the employee are not part of the system of records; provided, that the personal papers are not used by the employee or the board to determine any rights, benefits, or privileges of the individuals.

**655—11.2(17A,22,147,152,272C) Public information and inspection of records.**

**11.2(1) *Public information.*** Any interested person may examine public records of the board by making a written request. This request may be mailed or presented in person to the executive director or the designee at the office of the board. Records shall only be examined at the board office during the board’s regular business hours, Monday through Friday from 8 a.m. to 4:30 p.m., excluding legal holidays. Unless otherwise provided by law, all records other than confidential records, maintained by the board shall be made available for public inspection.

**11.2(2) *Inspection of records.*** Procedures governing requests for the inspection of records are set out in subrule 11.2(1).

**11.2(3) *Board records routinely available for public inspection.*** The board collects and maintains the following records that are routinely available for public inspection:

a. Board calendars, agenda, newsletter, news releases and other information intended for the public.

b. Board decisions, orders, opinions and other statements of law or policy issued by the board in the performance of its function.

c. The records of rule-making proceedings.

- d. Annual reports of the board.
- e. Reports and materials filed with the board by nursing education programs and continuing education providers.
- f. Board minutes except those resulting from meetings in closed sessions in accordance with Iowa Code section 21.5.
- g. Rulings on requests for waivers of board rules.
- h. Information about licensees (rosters and mailing lists).
- i. All of the records that are not specifically exempted from disclosure from subrule 11.2(4).

The board files of public records listed above may contain confidential records. Any request to review confidential records must be made in accordance with subrule 11.2(4). In addition, the board records listed in “a,” “b,” “d,” “f,” “g,” “h,” and “i” of this subrule may contain personally identifiable information.

Various legal and technical publications relating to nursing are also available for inspection by the public in the board office.

**11.2(4)** *Records not routinely available for public inspection.* The following records are not routinely available for public inspection. These records are withheld as specified in Iowa Code section 22.7.

a. Materials that are specifically exempted from disclosure by statute in which the board may in its discretion withhold from public inspection. Any person may request permission to inspect particular records withheld from inspection under this subrule. At the time of the request, the board will notify all interested parties. If the request is to review materials under this subrule, the board will withhold the materials from public inspection for 14 days to allow the party who submitted the materials an opportunity to seek injunctive relief.

b. Records which the board is authorized to withhold from public inspection under Iowa law include, but are not limited to, the following:

(1) Hospital records, medical records, and professional counselor records of the conditions, diagnosis, care, or treatment of a patient or former patient or a counselee or former counselee, including outpatient.

(2) Peace officers’ investigative reports as specified in Iowa Code section 22.7, except where disclosure is authorized elsewhere in the Code. However, the date, time, specific location, and immediate facts and circumstances surrounding a crime or incident shall not be kept confidential under this section, except in those unusual circumstances where disclosure would plainly and seriously jeopardize an investigation or pose a clear and present danger to the safety of an individual.

(3) Personnel records of board staff and board members which may be confidential pursuant to Iowa Code section 22.7(11). The board maintains files containing information about employees, their families and dependents, and applicants for positions with the board. The files may include payroll records, biographical information, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship.

(4) Information in a report to the state department of public health, to a local board of health, or to a local health department, which identifies a person infected with a reportable disease.

(5) Communications not required by law, rule, or procedure that are made to a government body or to any of its employees by identified persons outside of the government, to the extent that the government body receiving those communications from such persons outside of the government could reasonably believe that those persons would be discouraged from making them to that government body if they were available for general public examination. Notwithstanding this provision:

1. The communication is a public record to the extent that the person outside of government making that communication consents to its treatment as a public record.

2. Information contained in the communication is public record to the extent that it can be disclosed without directly or indirectly indicating the identity of the person outside of government making it or enabling others to ascertain the identity of that person.

3. Information contained in the communication is public record to the extent that it indicates the date, time, specific location, and immediate facts and circumstances surrounding the occurrence of a crime or other illegal act, except to the extent that its disclosure would plainly and seriously jeopardize a continuing investigation or pose a clear and present danger to the safety and danger of any person. In any action challenging the failure of the lawful custodian to disclose any particular information of the kind enumerated in this paragraph, the burden of proof is on the lawful custodian to demonstrate that the disclosure of that information would jeopardize an investigation or would pose a clear and present danger.

(6) Identifying details in final orders, decisions and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy under Iowa Code section 17A.3(1)“d.”

(7) Materials exempt from public inspection under any other provision of state law.

**11.2(5)** *Materials specifically exempt from disclosure by statute and which the board is prohibited from making available for public inspection.* The board is required to withhold the following materials from public inspection:

a. Records which include all complaint files, investigation files, other investigation reports and all other investigative information in the possession of the board or peer review committee acting under the authorization of the board or its employees or agents which relate to licensee application or discipline are privileged and confidential and are not subject to discovery, subpoena or other means of legal compulsion for their release to persons other than the licensee or applicant, the board, its employees and agents involved in licensee discipline. For further information and exceptions, see Iowa Code section 272C.6(4).

b. Minutes and tape recordings of portions of board meetings held in closed sessions in accordance with Iowa Code section 21.5(4).

c. Criminal history or prior misconduct of the examination applicant.

d. Information relating to the contents of the licensure examination.

e. Information relating to the examination results other than final score except for information about the results of the examination given to the person who took the examination.

**11.2(6)** *Requests that materials or information submitted to the board be withheld from public inspection.* Any person submitting information or materials to the board may submit a request that part or all of the information or materials not be made available for public inspection pursuant to the following requirements:

a. *Procedure.* The request shall be attached to the materials to which it applies, each page of which shall be clearly marked confidential.

b. *Content of the request.* Each request shall contain a statement of the legal basis for withholding the materials from inspection and the facts to support the legal basis relied upon. The facts underlying the legal basis shall be supported by affidavit executed by a corporate officer (or by an individual, if not a business entity) with personal knowledge of the specific facts. If the request is that the materials be withheld from inspection for a limited period of time, the period shall be specified.

c. *Compliance.* If a request complies with the requirements of paragraphs “a” and “b” of this subrule, the materials will be temporarily withheld from public inspection. The board will examine the documents to determine whether the documents should be afforded confidentiality. If the request is granted, the ruling will be placed in a public file in lieu of the materials withheld from public inspection.

d. *Request denied.* If a request for confidentiality is denied, the documents will be held confidential for 14 days to allow the applicant an opportunity to seek injunctive relief. After the 14 days expire, the materials will be available for public inspection, unless the board is directed by a court to keep the material confidential.

**11.2(7)** *Procedures for the inspection of board records which are routinely available for public inspection.* The records requested must be reasonably described by the person requesting them to permit their location by staff personnel. Members of the public will not be given access to the area in which records are kept and will not be permitted to search the files.

Advance requests to have records available on a certain date may be made by telephone or by correspondence.

*a. Search fees.* An hourly fee will be charged for searching for requested records. The fee will be based upon the pay scale of the employee who makes the search. No search fee will be charged if the records are not located, the records are not made available for inspection, or the search does not exceed one-quarter hour in duration.

*b. Written request.* Written requests shall list the telephone number (if any) of the person making the request, and for each document requested shall set out all available information which would assist in identifying and locating the document. The request should also set out the maximum search fee the person making the request is prepared to pay. If the maximum search fee is reached before all the requested documents have been located and copied the requesting person will be notified. When the requesting person requests that the board mail copies of the material, postage and handling expenses should also be included. Fees shall be paid directly to the board prior to the release of the requested information.

*c. Procedure for written request.* Records will be produced for inspection at the earliest possible date following a request. Records should be inspected within seven days after notice is given that the records have been located and are available for inspection or as otherwise agreed upon. After seven days, the records will be returned to storage and additional charges may be imposed for having to produce them again.

*d. Copies.* Copies of public records shall be made by the board staff and the charge shall be \$.10 per page.

**11.2(8)** *Procedures for inspection of board records which are not routinely available for public inspections.* Any person desiring to inspect board records which are not routinely available for public inspection shall file a request for inspection meeting the requirements of this subrule.

*a. Content of request.* The records must be reasonably described by the person requesting them so as to permit their location by staff personnel. Requests shall be directed to the Executive Director of the board.

*b. Procedure.* Requests for inspection shall be acted upon as follows:

(1) If the board is prohibited from disclosing the records, the request for inspection will be denied with a statement setting forth the specific grounds for denial.

(2) If the board is prohibited from disclosing part of a document from inspection, that part will be deleted and the remainder will be made available for inspection.

(3) In the case of requests to inspect records not routinely available for public inspection under subrule 11.2(4)“a”(1) through (9), the board will notify all interested parties of the request to view the materials. The board will withhold the materials from public inspection for 14 days to allow the party who submitted the material an opportunity to seek injunctive relief. If the request is granted by the board, or is partially granted and partially denied, the person who submitted the records to the board will be afforded 14 days from the date of the written ruling in which to seek injunctive relief. If injunctive relief is not requested within this period, the records will be produced for inspection.

**11.2(9)** *Procedure by which the subject of a confidential record may have a copy released to a named third party.* Upon request which complies with the following procedures, the board will disclose a confidential record to its subject or to a named third party designated by the subject. Positive identification is required of all individuals making a request.

*a. In person request.* Subjects of a confidential record who request that information be given to a named third party will be asked for positive means of identification. If an individual cannot provide suitable identification, the request will be denied.

Subjects of a confidential record who request that information be given to a named third party will be asked to sign a release form before records are disclosed.

*b. Written request.* All requests by subject of a confidential board record for release of the information to a named third party sent by mail shall be signed by the requester and shall include the requester’s current address and telephone number (if any). If positive identification cannot be made on the basis of the information submitted along with the information contained in the record, the request will be denied.

Subjects of a confidential record who request by mail that information be given to a named third party will be asked to sign a release form before the records are disclosed.

*c. Denial of access to the record.* If positive identification cannot be made on the basis of the information submitted or if data in the record are so sensitive that authorized access could cause harm or embarrassment to the individual to whom the record pertains, the board may deny access to the record pending the production of additional evidence of identity.

**11.2(10) Procedure by which the subject of a board record may have additions, dissents or objections entered into the record.** An individual may request an addition, dissent or any objection be entered into a board record which contains personally identifiable data pertaining to that individual. The request shall be acted on within a reasonable time.

*a. Content of the request.* The request must be in writing and addressed to the Executive Director of the board. The request should contain the following information:

- (1) A reasonable description of the pertinent record.
- (2) Verification of identity.
- (3) The requested addition, dissent or objection.
- (4) The reason for the requested addition, dissent or objection to the record.

*b. Denial of request.* If the request is denied, the requester will be notified in writing of the refusal and will be advised that the requester may seek board review of the denial within 20 working days after issuance of the denial.

**11.2(11) Advice and assistance.** Individuals who have questions regarding the procedures contained in these rules may contact the Executive Director of the board.

**11.2(12) Data processing system.** The board does not currently have a data processing system which matches, collates or permits the comparison of personally identifiable information in one record system with personally identifiable information on another record system.

### **655—11.3(17A,22,147,152,272C) Personally identifiable information.**

**11.3(1) Collection of personally identifiable information.** This board is authorized to collect information, some of which is personally identifiable. The nature and extent of the personally identifiable information collected by the board, the legal authority for the collection of that information and a description of the means of storage are found in this section.

**11.3(2) Personally identifiable information.** The board maintains the following systems of records which may contain personally identifiable information:

*a. Rule making.* Rule-making records may contain information about individuals making written or oral comments or proposed rules. This information is collected pursuant to Iowa Code section 17A.4. This information is not retrieved by individual identifier, and is not stored in an automated data processing system.

*b. Board records.* Agendas, minutes and materials presented to all board members in preparation for board meetings are available from the Executive Director, except those records concerning closed sessions which are exempt from disclosure under Iowa Code section 21.5(4).

*c. Publications.* News releases, annual reports, project reports, board newsletters, etc. are available from the office of the Executive Director.

Board news releases, annual reports, project reports, and newsletters may contain personally identifiable information about board staff or members of the board or committees. This information is not retrieved by individual identifier and is not stored on an automated data processing system.

*d. Disciplinary reports.* This information is available from the chief health professions investigator in the board office. These reports contain personally identifiable information about nurses who have had action taken by the board against their licenses. This information is retrieved by individual identifier and some of the information is stored on an automated data processing system. Some is stored as hard copy or microfilmed documents. This information is matched or compared with personally identifiable information in other record systems.

This information is dispersed pursuant to Iowa Code sections 272C.4 and 272C.6.

*e. Declaratory rulings.* Records may contain information about individuals making the requests for declaratory rulings or comments from other individuals concerning the rulings. This information is collected pursuant to Iowa Code section 17A.9. This information is retrieved by the individual requesting the ruling or topic and is not stored on an automated data processing system.

*f. Licensing.*

(1) Records pertaining to licensure by examination may include:

1. Transcripts from nursing education programs. This information is collected pursuant to Iowa Code section 152.7.

2. Application for licensure by examination. This information is collected pursuant to Iowa Code sections 147.8 and 147.29.

3. Application for licensure by endorsement. This information is collected pursuant to Iowa Code section 147.44.

4. Birth certificates (part of previous requirement for licensure; no longer required). This information is collected pursuant to Iowa Code section 147.3.

5. References.

6. Past felony record. This information is collected pursuant to Iowa Code section 147.3.

7. Examination scores. This information is collected pursuant to Iowa Code section 152.7.

8. High school graduation or equivalency. This information is collected pursuant to Iowa Code section 152.7.

9. Certification for advanced registered nurse practice. This information is collected pursuant to Iowa Code section 152.1(2)“d.”

(2) Records pertaining to licensure by endorsement may include:

1. Transcripts from nursing education programs. This information is collected pursuant to Iowa Code section 152.7.

2. Application for licensure by endorsement. This information is collected pursuant to Iowa Code section 152.8.

3. Birth certificates (part of previous requirement; no longer required). This information is collected pursuant to Iowa Code section 147.3.

4. Past felony record. This information is collected pursuant to Iowa Code section 147.3.

5. Examination scores. This information is collected pursuant to Iowa Code section 152.7.

6. Disciplinary action taken by other boards of nursing. This information is collected pursuant to Iowa Code section 147.52.

7. High school graduation or equivalency. This information is collected pursuant to Iowa Code section 152.7.

8. Verification of licensure by another board of nursing. This information is collected pursuant to Iowa Code section 152.8.

(3) Licensure by renewal, reinstatement and reactivation.

1. Applications. This information is collected pursuant to Iowa Code sections 147.10 and 147.11.

2. Past felony record. This information is collected pursuant to Iowa Code section 147.3.

3. Continuing education records. This information is collected pursuant to Iowa Code section 272C.2.

**11.3(3) Retrieval of personally identifiable information.** Personally identifiable information is retrieved by individual identifier and some of this information is stored in an automated data processing system. Some is stored as hard copy or microfilmed documents. All record systems maintained by the board and which contain personally identifiable information permit the comparison of personally identifiable information in one record system with personally identifiable information in another system.

**11.3(4) Board procedures for requesting information.** After July 1, 1988, the board shall notify persons supplying information requested by the agency of the use that will be made of the information, which persons outside the department might routinely be provided this information, which parts of the information requested are required and which are optional, and the consequences of failing to provide the

information requested. This notification shall either appear on the form used to collect the information, or on a separate sheet accompanying the form.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—11.4(17A,22,147,152,272C) Notice to suppliers of information.** When the board requests a person to supply personal information, the board shall notify the person of the use that will be made of the information, which persons outside the board might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the requested information. This notice may be given in these rules, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means.

**11.4(1) License and examination applicants.** License and examination applicants are requested to supply a wide range of information depending on the qualifications required for licensure or for sitting for an examination, as provided by statutes, board rules and application forms. Failure to provide the requested information may result in denial of the application. Some requested information, such as a college transcript, social security number, examination score, or criminal history, is confidential under state or federal law, but most of the information contained in license or examination applications is treated as public information freely available for public examination.

**11.4(2) Home address.** License applicants and licensees are requested to provide their home addresses. These addresses are treated as open records. If a license applicant or licensee has a basis to shield a home address from public disclosure, such as a domestic abuse protective order, written notification should be provided to the board office. Absent a court order, the board does not have a basis under Iowa Code chapter 22 to shield the home address from public disclosure, but the board shall refrain from placing the home address on its Web site and may notify the applicant or licensee before the home address is released to the public to provide an opportunity for the applicant or licensee to seek injunction.

**11.4(3) License renewal.** Licensees are requested to supply a wide range of information in connection with license renewal, including continuing education information, criminal history and disciplinary actions, as provided by statutes, board rules and application forms, both on paper and electronically. Failure to provide requested information may result in denial of the application. Most information contained on renewal applications is treated as public information freely available for public examination, but some information, such as criminal history, may be confidential under state or federal law.

**11.4(4) Investigations.** Licensees are required to respond to board requests for information involving the investigation of disciplinary complaints against licensees. Failure to timely respond may result in disciplinary action against the licensee to whom the request is made. Information provided in response to such a request is confidential pursuant to Iowa Code section 272C.6(4), but may become public if introduced at a hearing that is open to the public, contained in a final order, or filed with a court of judicial review.

**655—11.5(17A,22,147,152,272C) Rosters.** Rosters of licensees shall be made available to the public in accordance with Iowa Code chapter 22 and sections 147.8 and 147.43.

**11.5(1)** Rosters may be accessed via the board's Web site under IBON Online Services and Purchase a Roster.

**11.5(2)** A fee of \$40 per data set shall be charged for a roster.

**11.5(3)** The executive director may authorize the release of a roster of Iowa licensees without cost in the case of any emergency whereby the interest of the public warrants immediate access to health care personnel.

**11.5(4)** State agencies will be provided an electronic file of the roster at no cost.

[ARC 1174C, IAB 11/13/13, effective 12/18/13]

These rules are intended to implement Iowa Code chapters 147, 152 and 272C.

[Filed 3/24/88, Notice 1/13/88—published 4/20/88, effective 5/25/88]

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CHAPTER 20  
CONTESTED CASES  
[Prior to 1/6/16, see 655—Chapter 4]

**655—20.1(17A,272C) Scope and applicability.** This chapter applies to contested case proceedings conducted by the Iowa board of nursing.  
[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.2(17A,272C) Definitions.** Except where otherwise specifically defined by law:

“*Board*” means a quorum of members of the Iowa board of nursing.

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5), including but not limited to licensee disciplinary proceedings, adverse agency action to limit or revoke the multistate licensure privilege granted under the provisions of the nurse licensure compact, license denial proceedings, and license reinstatement proceedings.

“*Issuance*” means the date of mailing of a decision or order, or date of delivery if service is by other means, unless another date is specified in the order.

“*Party*” means the state of Iowa, as represented by the office of the attorney general, and the respondent or applicant.

“*Probable cause*” means a reasonable ground for belief in the existence of facts warranting the specified proceeding.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.3(17A,272C) Time requirements.** Time shall be computed as provided in Iowa Code section 4.1(34). For good cause, the presiding officer may lengthen or shorten the time to take any action, except as precluded by statute or by rule. Except for good cause stated in the record, before lengthening or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.4(17A,272C) Applicability of Iowa Rules of Civil Procedure.** Except as expressly provided in Iowa Code chapter 17A and these rules, the Iowa Rules of Civil Procedure do not apply to contested case proceedings. However, upon application by a party, the board may permit the use of procedures provided for in the Iowa Rules of Civil Procedure unless doing so would unreasonably complicate the proceedings or impose an undue hardship on a party.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.5(17A,272C) Combined statement of charges and settlement agreement.** Upon a determination by the board that probable cause exists to take public disciplinary action, the board and the licensee may enter into a combined statement of charges and settlement agreement.

**20.5(1)** No licensee is entitled to be offered a combined statement of charges and settlement agreement.

**20.5(2)** Entering into a combined statement of charges and settlement agreement is completely voluntary.

**20.5(3)** The combined statement of charges and settlement agreement shall include a brief statement of the charges, the circumstances that led to the charges, and the terms of settlement.

**20.5(4)** A combined statement of charges and settlement agreement shall constitute the commencement and resolution of a contested case proceeding. By entering into a combined statement of charges and settlement agreement, the licensee waives the right to a contested case hearing on the matter.

**20.5(5)** A combined statement of charges and settlement agreement is a permanent public record open for inspection under Iowa Code chapter 22.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.6(17A,272C) Notice of hearing.**

**20.6(1) Delivery.** Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery may be executed by:

- a. Personal service, as provided in the Iowa Rules of Civil Procedure; or
- b. Certified restricted mail, return receipt requested; or
- c. Signed acknowledgment accepting service; or
- d. When service cannot be accomplished using the above methods:
  - (1) An affidavit shall be prepared outlining the measures taken to attempt service; and
  - (2) Notice of hearing shall be published once each week for three consecutive weeks in a newspaper

of general circulation, published or circulated in the county of last-known residence of the respondent. The first notice of hearing shall be published at least 30 days prior to the scheduled hearing.

**20.6(2) Contents.** The notice of hearing shall contain the following information:

- a. A statement of the time, place, and nature of the hearing;
- b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the particular sections of the statutes and rules involved;
- d. A short and plain statement of the matters asserted;
- e. Identification of all parties, including the name, address and telephone number of the assistant attorney general representing the state;
- f. Reference to the procedural rules governing conduct of the contested case proceeding;
- g. Reference to the procedural rules governing settlement;
- h. Identification of the presiding officer;
- i. Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11, that the presiding officer be an administrative law judge;
- j. Notification of the time period in which the respondent may file an answer; and
- k. Notification of the respondent's right to request a closed hearing, if applicable.

**20.6(3) Public record.** Notices of hearing are permanent public records open for inspection under Iowa Code chapter 22.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.7(17A,272C) Statement of charges.** In the event the board finds there is probable cause for taking public disciplinary action against a licensee, the board shall file a statement of charges. The statement of charges shall be incorporated within the notice of hearing. The statement of charges shall set forth the acts or omissions with which the respondent is charged including the statute(s) and rule(s) which are alleged to have been violated and shall be in sufficient detail to enable the preparation of the respondent's defense. Every statement of charges prepared by the board shall be reviewed by the office of the attorney general before it is filed. Statements of charges are permanent public records open for inspection under Iowa Code chapter 22.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.8(13,272C) Legal representation.** Following the issuance of a notice of hearing, the office of the attorney general shall be responsible for the legal representation of the public interest in the contested case. The assistant attorney general assigned to prosecute a contested case before the board shall not represent the board in that case but shall represent the public interest.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.9(17A,272C) Presiding officer in a disciplinary contested case.** The presiding officer in a disciplinary contested case shall be the board. When acting as presiding officer, the board may request that an administrative law judge perform certain functions as an aid to the board, such as ruling on prehearing motions, conducting the prehearing conference, ruling on evidentiary objections at hearing, assisting in deliberations, and drafting the written decision for review by the board.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.10(17A,272C) Presiding officer in a nondisciplinary contested case.**

**20.10(1)** Any party in a nondisciplinary contested case who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must file a written request within 20 days after service of the notice of hearing.

**20.10(2)** The board may deny the request only upon a finding that one or more of the following apply:

- a. There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.
- b. An administrative law judge is unavailable to hear the case within a reasonable time.
- c. The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.
- d. The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.
- e. Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.
- f. The request was not timely filed.
- g. The request is not consistent with a specified statute.

**20.10(3)** The board shall issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge, the parties shall be notified at least 10 days prior to hearing if an administrative law judge will not be available.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.11(17A,272C) Disqualification.**

**20.11(1)** A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- a. Has a personal bias or prejudice concerning a party or a representative of a party.
- b. Has personally investigated, prosecuted, or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties. If the licensee elects to appear before the board in the investigative process, the licensee waives this provision.
- c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties.
- d. Has acted as counsel to any person who is a private party to that proceeding within the past two years.
- e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case.
- f. Has a spouse or relative within the third degree of relationship who:
  - (1) Is a party to the case, or an officer, director or trustee of a party;
  - (2) Is a lawyer in the case;
  - (3) Is known to have an interest that could be substantially affected by the outcome of the case; or
  - (4) Is likely to be a material witness in the case.
- g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

**20.11(2)** The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include:

- a. General direction and supervision of assigned investigators;
- b. Unsolicited receipt of information which is relayed to assigned investigators;
- c. Review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding; or
- d. 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.

Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17(3) and subrules 20.11(3) and 20.28(8).

By electing to participate in an appearance before the board, the licensee waives any objection to a board member's both participating in the appearance and later participating as a decision maker in a contested case proceeding on the grounds that the board member "personally investigated" the matter under this provision.

**20.11(3)** In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

**20.11(4)** If a party asserts disqualification on any appropriate ground, including those listed in subrule 20.11(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.11(3). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. The individual against whom disqualification is asserted shall make the initial determination as to whether disqualification is required. If the individual elects not to disqualify, the board shall make the final determination as to disqualification of that individual as part of the record in the case.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.12(17A,272C) Waiver of procedures.** Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the board in its discretion may refuse to give effect to such a waiver when the board deems the waiver to be inconsistent with the public interest.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.13(17A,272C) Telephone or electronic proceedings.** The presiding officer may resolve prehearing matters by telephone conference in which all parties have an opportunity to participate. Contested case hearings will generally not be held by telephone or electronic means in the absence of consent by all parties under compelling circumstances. Nothing shall prohibit a witness from testifying by telephone or electronic means pursuant to paragraph 20.26(3) "b."

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.14(17A,272C) Consolidation—severance.**

**20.14(1) Consolidation.** The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where: (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

**20.14(2) Severance.** The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.15(17A,272C) Appearance.** The respondent or applicant may be represented by an attorney. The attorney must file an appearance in the contested case. If the attorney is not licensed to practice law in Iowa, the attorney must fully comply with Iowa Court Rule 31.14.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.16(17A,272C) Answer.** An answer may be filed within 20 days of service of the notice of hearing and statement of charges. An answer shall specifically admit, deny, or otherwise answer all material allegations of the statement of charges to which it responds. It shall state any facts supporting any affirmative defenses and contain as many additional defenses as the respondent may claim. An answer shall state the name, address and telephone number of the person filing the answer. Any allegation in the statement of charges not denied in the answer is considered admitted. The presiding officer may

refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.17(17A,272C) Filing and service of documents.**

**20.17(1) Filing—when required.** After the notice of hearing, all documents in a contested case proceeding shall be filed with the board.

**20.17(2) Filing—how made.** Filing shall be made by delivering or mailing the document to the board office located at 400 S.W. 8th Street, Suite B, Des Moines, Iowa 50309-4685.

**20.17(3) Filing—when made.** A document is deemed filed at the time it is delivered to the board office, delivered to an established courier service for immediate delivery to the board office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

**20.17(4) Service—when required.** Except as otherwise provided by law, every document filed in a contested case proceeding shall be simultaneously served upon each of the parties of record to the proceeding, including the assistant attorney general representing the state. Except for an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

**20.17(5) Service—how made.** Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order, so long as there is proof of mailing.

**20.17(6) Electronic service.** Service may be made upon a party or attorney by electronic mail (e-mail) if the person consents in writing in that case to be served in that manner. The written consent shall specify the e-mail address for such service. The written consent may be withdrawn by written notice served on the parties or attorneys.

**20.17(7) Proof of mailing/e-mailing.** Proof of mailing/e-mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the (agency office and address) and to the names and addresses of the parties listed below by depositing the same in the United States mail, state interoffice mail, or e-mail when permitted by 655 IAC 20.17(6).

(Date)

(Signature)

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.18(272C) Investigative file.** The board's investigative file is available to the respondent or applicant upon request only after the commencement of a contested case and only prior to the resolution of the contested case. A licensee who elects to enter into a combined statement of charges and settlement agreement is not entitled to request the investigative file. In accordance with Iowa Code section 272C.6(4), information contained within an investigative file is confidential and may only be used in connection with the disciplinary proceedings before the board.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.19(17A,272C) Discovery.**

**20.19(1)** The scope of discovery described in Iowa Rule of Civil Procedure 1.503 shall apply to contested case proceedings.

**20.19(2)** The following discovery procedures available in the Iowa Rules of Civil Procedure are available to the parties in a contested case proceeding: depositions upon oral examination or written questions; written interrogatories; production of documents, electronically stored information, and things; and requests for admission. Unless lengthened or shortened by the presiding officer, the time frames for discovery in the specific Iowa Rules of Civil Procedure govern those specific procedures.

*a.* Iowa Rules of Civil Procedure 1.701 through 1.717 regarding depositions shall apply to any depositions taken in a contested case proceeding. Any party taking a deposition in a contested case shall be responsible for any deposition costs, unless otherwise specified or allocated in an order. Deposition costs include, but are not limited to, reimbursement for mileage of the deponent, costs of a certified shorthand reporter, and expert witness fees, as applicable.

*b.* Iowa Rule of Civil Procedure 1.509 shall apply to any interrogatories propounded in a contested case proceeding.

*c.* Iowa Rule of Civil Procedure 1.512 shall apply to any requests for production of documents, electronically stored information, and things in a contested case proceeding.

*d.* Iowa Rule of Civil Procedure 1.510 shall apply to any requests for admission in a contested case proceeding. Iowa Rule of Civil Procedure 1.511 regarding the effect of an admission shall apply in contested case proceedings.

**20.19(3)** The mandatory disclosure and discovery conference requirements in Iowa Rules of Civil Procedure 1.500 and 1.507 do not apply to contested case proceedings. However, upon application by a party, the board may order the parties to comply with these procedures unless doing so would unreasonably complicate the proceedings or impose an undue hardship.

**20.19(4)** Iowa Rule of Civil Procedure 1.508 shall apply to discovery of any experts identified by a party to a contested case proceeding.

**20.19(5)** Discovery shall be served on all parties to the contested case proceeding but shall not be filed with the board.

**20.19(6)** A party may file a motion to compel or other motion related to discovery in accordance with this subrule. Any motion filed with the board relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within 10 days of the filing of the motion unless the time is lengthened or shortened by the presiding officer. The presiding officer may rule on the basis of the written motion and any response or may order argument on the motion.

**20.19(7)** Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

#### **655—20.20(17A,272C) Issuance of subpoenas in a contested case.**

**20.20(1)** Subpoenas issued in a contested case may compel the attendance of witnesses at deposition or hearing and may compel the production of books, papers, records, and other real evidence. A command to produce evidence or to permit inspection may be joined with a command to appear at deposition or hearing or may be issued separately. Subpoenas shall be issued by the executive director or designee upon a written request that complies with the requirements of this rule. A request for a subpoena of mental health records must confirm that the conditions described in subrule 20.20(3) have been satisfied prior to the issuance of the subpoena. The executive director or designee may refuse to issue a subpoena if the request does not comply with the requirements of this rule.

**20.20(2)** A request for a subpoena shall include the following information, as applicable, unless the subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes:

- a.* The name, address and telephone number of the person requesting the subpoena;
- b.* The name and address of the person to whom the subpoena shall be directed;
- c.* The date, time and location at which the person shall be commanded to attend and give testimony;
- d.* Whether the testimony is requested in connection with a deposition or hearing;
- e.* A description of the books, papers, records or other real evidence requested and the date, time and location for production or inspection and copying; and
- f.* In the case of a subpoena request for mental health records, confirmation that the conditions described in subrule 20.20(3) have been satisfied.

**20.20(3)** In the case of a request for a subpoena of mental health records, the request must confirm compliance with the following conditions prior to the issuance of the subpoena:

- a.* The nature of the issues in the case reasonably justifies the issuance of the requested subpoena;
- b.* Adequate safeguards have been established to prevent unauthorized disclosure;
- c.* An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and
- d.* An attempt was made to notify the patient and to secure an authorization from the patient for the release of the records at issue.

**20.20(4)** Each subpoena shall contain, as applicable, the following:

- a.* The caption of the case;
- b.* The name, address and telephone number of the person who requested the subpoena;
- c.* The name and address of the person to whom the subpoena is directed;
- d.* The date, time and location at which the person is commanded to appear;
- e.* Whether the testimony is commanded in connection with a deposition or hearing;
- f.* A description of the books, papers, records or other real evidence the person is commanded to produce;
- g.* The date, time and location for production or inspection and copying;
- h.* The time within which the motion to quash or modify the subpoena must be filed;
- i.* The signature, address and telephone number of the executive director or designee;
- j.* The date of issuance;
- k.* A return of service.

**20.20(5)** Unless a subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes, the executive director or designee shall mail copies of all subpoenas to the parties. The person who requested the subpoena is responsible for serving the subpoena upon the subject of the subpoena.

**20.20(6)** Any person who is aggrieved or adversely affected by compliance with the subpoena or any party to the contested case who desires to challenge the subpoena must, within 14 days after service of the subpoena, or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

**20.20(7)** Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to issue a decision or the board may issue a decision. Oral argument may be scheduled at the discretion of the board or the administrative law judge. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

**20.20(8)** A person aggrieved by a ruling of an administrative law judge who desires to challenge that ruling must appeal the ruling to the board by serving on the executive director in accordance with subrule 20.17(5) a notice of appeal within 10 days after service of the decision of the administrative law judge.

**20.20(9)** If the person contesting the subpoena is not a party to the contested case proceeding, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is a party to the contested case proceeding, the board's decision is not final for purposes of judicial review until there is a final decision in the contested case.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

### **655—20.21(17A,272C) Motions.**

**20.21(1)** No technical form for motions is required. Prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

**20.21(2)** Any party may file a written response to a motion within 10 days after the motion is served, unless the time period is lengthened or shortened by rules of the board or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

**20.21(3)** The presiding officer may schedule oral argument on any motion.

**20.21(4)** Motions pertaining to the hearing must be filed and served at least 10 days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the board or the presiding officer.

**20.21(5)** Dispositive motions, such as motions for summary judgment or motions to dismiss, must be filed with the board and served on all parties to the contested case proceeding at least 30 days prior to the scheduled hearing date, unless otherwise ordered or permitted by the presiding officer. Any party may file a written response to a dispositive motion within 10 days after the motion is served, unless the time for response is otherwise lengthened or shortened by the presiding officer.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.22(17A,272C) Prehearing conferences.**

**20.22(1)** Any party may request a prehearing conference. Prehearing conferences shall be conducted by the executive director, who may request that an administrative law judge conduct the prehearing conference. A written request for prehearing conference or an order for prehearing conference on the executive director's own motion shall be filed not less than 7 days prior to the hearing date, unless authorized by the person conducting the prehearing conference. A prehearing conference shall be scheduled not less than 3 business days prior to the hearing date.

**20.22(2)** Each party shall be prepared to discuss the following subjects at the prehearing conference:

*a.* Submission of expert and other witness lists. Witness lists may be amended subsequent to the prehearing conference within the time limits established by the executive director or administrative law judge at the prehearing conference. Any such amendments must be served on all parties. Witnesses not listed on the final witness list may be excluded from testifying unless there was good cause for the failure to include their names.

*b.* Submission of exhibit lists. Exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the executive director or administrative law judge at the prehearing conference. Other than rebuttal exhibits, exhibits that are not listed on the final exhibit list may be excluded from admission into evidence unless there was good cause for the failure to include them.

*c.* The entry of a scheduling order to include deadlines for completion of discovery.

*d.* Stipulations of law or fact.

*e.* Stipulations on the admissibility of exhibits.

*f.* Identification of matters which the parties intend to request be officially noticed.

*g.* Consideration of any additional matters which will expedite the hearing.

**20.22(3)** Prehearing conferences shall be conducted by telephone unless otherwise ordered.

**20.22(4)** A party must seek intra-agency appeal to the board of prehearing rulings made by an administrative law judge in order to adequately exhaust administrative remedies. Such appeals must be filed within 10 days of the date of the issuance of the challenged ruling but no later than the time for compliance with the order or the date of hearing, whichever is first.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.23(17A,272C) Continuances.** Unless otherwise provided, requests for continuance shall be filed with the board.

**20.23(1)** A written request for a continuance shall:

*a.* Be made at the earliest possible time and no less than 7 days before the hearing except in cases of unanticipated emergencies;

*b.* State the specific reasons for the request; and

*c.* Be signed by the requesting party or the party's attorney.

**20.23(2)** No request for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The presiding officer may allow an oral application for continuance at the contested case hearing only in the event of an unanticipated emergency.

**20.23(3)** The presiding officer or the executive director has the authority to grant or deny a request for a continuance in accordance with this subrule. The executive director or an administrative law judge may enter an order granting an uncontested request for a continuance. Upon consultation with the board chair,

the executive director or an administrative law judge may deny an uncontested request for a continuance or may rule on a contested request for continuance.

**20.23(4)** In determining whether to grant a continuance, the presiding officer or the executive director may require documentation of any grounds for continuance and may consider:

- a.* Prior continuances;
- b.* The interests of all parties;
- c.* The public interest;
- d.* The likelihood of settlement;
- e.* The existence of an emergency;
- f.* Any objection;
- g.* Any applicable time requirements;
- h.* The existence of a conflict in the schedules of counsel, parties, or witnesses;
- i.* The timeliness of the request; and
- j.* Other relevant factors.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.24(17A,272C) Settlement agreements.**

**20.24(1)** A contested case may be resolved by settlement agreement. Settlement negotiations may be initiated by any party at any stage of a contested case. No party is required to participate in the settlement process.

**20.24(2)** If the respondent initiates or consents to settlement negotiations, the assistant attorney general prosecuting the case may discuss settlement with the board chair without violating the prohibition against ex parte communications in Iowa Code section 17A.17 and without disqualifying the board chair from participating in the adjudication of the contested case. The full board shall not be involved in settlement negotiations until a proposed settlement agreement executed by the respondent is submitted to the board for approval.

**20.24(3)** By signing the proposed settlement agreement, the respondent authorizes an assistant attorney general to have ex parte communications with the board related to the terms of the proposed settlement. If the board fails to approve the proposed settlement agreement, it shall be of no force or effect to either party and shall not be admissible at hearing. Upon rejecting a proposed settlement agreement, the board may suggest alternative terms of settlement, which the respondent is free to accept or reject.

**20.24(4)** A settlement agreement is a permanent public record open for inspection under Iowa Code chapter 22.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.25(17A,272C) Hearing procedures in contested cases.**

**20.25(1)** The presiding officer shall be in control of the proceedings and shall have the authority to administer oaths and to admit or exclude testimony or evidence and shall rule on all motions and objections. The board may request that an administrative law judge assist the board by performing any of these functions.

**20.25(2)** When, in the opinion of the board, it is desirable to obtain specialists within an area of practice when holding disciplinary hearings, the board may appoint a panel of three specialists who are not board members to make findings of fact and to report to the board. Such findings shall not include any recommendation for or against licensee discipline.

**20.25(3)** An applicant or respondent has the right to participate or to be represented in all hearings related to the applicant's or respondent's case. Any applicant or respondent may be represented by an attorney at the party's own expense.

**20.25(4)** All objections shall be timely made and stated on the record.

**20.25(5)** Subject to terms prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, submit briefs, and engage in oral argument.

**20.25(6)** The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

**20.25(7)** All rulings by an administrative law judge who acts either as presiding officer or as an aid to the board are subject to appeal to the board. While a party may seek immediate board review of rulings made by an administrative law judge when the administrative law judge is sitting with and acting as an aid to the board or panel of specialists during a hearing, such immediate review is not required to preserve error for judicial review.

**20.25(8)** Conduct of hearing. The presiding officer shall conduct the hearing in the following manner:

*a.* The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

*b.* The parties shall be given an opportunity to present opening statements;

*c.* Parties shall present their cases in the sequence determined by the presiding officer;

*d.* Each witness shall be sworn or affirmed by the presiding officer or the court reporter and be subject to examination and cross-examination. The board members and administrative law judge have the right to question a witness. The presiding officer may limit questioning in a manner consistent with law;

*e.* When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

**20.25(9)** The hearing shall be open to the public unless the respondent requests that the hearing be closed, in accordance with Iowa Code section 272C.6(1). At the request of either party, or on the board's own motion, the presiding officer may issue a protective order to protect documents which are privileged or confidential by law.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

#### **655—20.26(17A,272C) Evidence.**

##### **20.26(1) General.**

*a.* Relevant evidence is admissible, subject to the discretion of the presiding officer. Irrelevant, immaterial and unduly repetitious evidence should be excluded. A finding will be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based on hearsay or other types of evidence which may or would be inadmissible in a jury trial.

*b.* The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

*c.* Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

*d.* Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

*e.* Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

*f.* Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

**20.26(2) Exhibits.**

*a.* The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties. If admitted, copies of documents should be distributed to individual board members and the administrative law judge. Unless prior arrangements have been made, the party seeking admission of a document should arrive at the hearing prepared with sufficient copies of the document to distribute to opposing parties, board members, the administrative law judge, and witnesses who are expected to examine the document. The state's exhibits shall be marked numerically, and the applicant's or respondent's exhibits shall be marked alphabetically.

*b.* All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

*c.* An original is not required to prove the content of a writing, recording, or photograph. Duplicates or photocopies are admissible. Any objection related to the authenticity of an exhibit shall go to the weight given to that exhibit and not preclude its admissibility.

**20.26(3) Witnesses.**

*a.* Witnesses may be sequestered during the hearing.

*b.* Subject to the terms prescribed by the presiding officer and the limitations in Iowa Rule of Civil Procedure 1.704, parties may present the testimony of witnesses in person, by telephone, by videoconference, by affidavit, or by written or video deposition. If a witness is providing testimony in person, by telephone, or by videoconference, use of any deposition is limited by Iowa Rule of Civil Procedure 1.704.

*c.* Witnesses are entitled to be represented by an attorney at their own expense. In a closed hearing, the attorney may be present only when the client testifies. The attorney may assert legal privileges personal to the client, but may not make other objections. The attorney may only ask questions to the client to prevent a misstatement from being entered into the record.

*d.* The parties in a contested case shall be responsible for any witness fees and expenses incurred by witnesses appearing at the contested case hearing, unless otherwise specified or allocated in an order. The costs for lay witnesses shall be determined in accordance with Iowa Code section 622.69. The costs for expert witnesses shall be determined in accordance with Iowa Code section 622.72. Witnesses are entitled to reimbursement for mileage and may be entitled to reimbursement for meals and lodging, as incurred.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.27(17A,272C) Default.**

**20.27(1)** If a party 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 and render a decision in the absence of the party.

**20.27(2)** Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

**20.27(3)** Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 655—20.30(17A,272C). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit from a person with personal knowledge of each such fact. The affidavit(s) must be attached to the motion.

**20.27(4)** The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

**20.27(5)** Properly substantiated and 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. Adverse parties shall have

10 days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

**20.27(6)** "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 1.971.

**20.27(7)** A decision by an administrative law judge granting or denying a motion to vacate is subject to appeal to the board within 20 days.

**20.27(8)** If a motion to vacate is granted and no timely appeal to the board has been filed, the presiding officer shall issue a rescheduling order setting a new hearing date and the contested case shall proceed accordingly.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.28(17A,272C) Ex parte communication.**

**20.28(1)** Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case, except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 20.11(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties, as long as those persons do 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.

**20.28(2)** 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.

**20.28(3)** Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

**20.28(4)** To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 655—20.17(17A,272C) and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through telephone conference call which includes all parties or their representatives.

**20.28(5)** Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

**20.28(6)** The executive director or designee may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as the executive director or designee is not disqualified from participating in the making of a proposed or final decision under subrule 20.11(1) or other law and the executive director or designee complies with subrule 20.28(1).

**20.28(7)** Communications with the presiding officer involving scheduling or uncontested procedural matters do not require notice or opportunity for parties to participate. A party should notify other parties prior to initiating such contact with the presiding officer when feasible.

**20.28(8)** A presiding officer who received 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. 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 submitted for inclusion in the record under seal by protective order. 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 10 days after notice of the communication.

**20.28(9)** Promptly after being assigned to serve as presiding officer, the 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.

**20.28(10)** 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 board. Violation of ex parte communication prohibitions by board personnel shall be reported to the board's executive director for possible sanctions including: censure, suspension, dismissal, or other disciplinary action.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.29(17A,272C) Recording.** Contested case hearings shall be recorded by electronic means or by a certified shorthand reporter. A party may request that a hearing be recorded by a certified shorthand reporter instead of through electronic means by filing a request with the board at least 14 days in advance of the hearing. Parties who request that a hearing be recorded by a certified shorthand reporter rather than by electronic means shall bear the cost of the certified shorthand reporter. Upon request, the board shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party. If the request for the hearing record is made as a result of a petition for judicial review, the party who filed the petition shall be considered the requesting party.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.30(17A,272C) Proposed decisions.** Decisions issued by an administrative law judge in nondisciplinary cases are proposed decisions. A proposed decision issued by an administrative law judge becomes a final decision if not timely appealed or reviewed in accordance with this rule.

**20.30(1) Appeal by party.** Any adversely affected party may appeal a proposed decision to the board within 30 days after issuance of the proposed decision.

**20.30(2) Review.** The board may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

**20.30(3) Exhaustion.** A party must timely seek intra-agency appeal of a proposed decision in order to adequately exhaust administrative remedies.

**20.30(4) Notice of appeal.** An appeal of a proposed decision is initiated by filing a timely notice of appeal with the board. The notice of appeal must be signed by the appealing party or an attorney for that party and contain a certificate of service. The notice shall specify:

- a. The parties initiating the appeal;
- b. The proposed decision or order which is being appealed;
- c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;
- d. The relief sought;
- e. The grounds for relief.

**20.30(5) Requests to present additional evidence.** A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The board may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

**20.30(6) Scheduling.** The board shall issue a schedule for consideration of the appeal.

**20.30(7) Briefs and arguments.** Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs. The board may resolve the appeal on the briefs or provide an opportunity for oral argument. The board may shorten or extend the briefing period as appropriate.

**20.30(8) Record.** The record on appeal or review shall be the entire record made before the administrative law judge.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.31(17A,272C) Final decisions.**

**20.31(1)** A final decision of the board shall include findings of fact and conclusions of law. When the board presides over the reception of the evidence at the hearing, its decision is a final decision.

**20.31(2)** The board may charge a fee to the licensee not to exceed \$75 for conducting a disciplinary hearing which results in disciplinary action taken against the licensee by the board.

**20.31(3)** Final decisions shall be served on the respondent or applicant using one of the following methods:

- a. Personal service, as provided in the Iowa Rules of Civil Procedure, or
- b. Certified mail, return receipt requested, or
- c. Signed acknowledgment accepting service, or
- d. When service cannot be accomplished using the above methods:
  - (1) An affidavit shall be prepared outlining the measures taken to attempt service; and
  - (2) The final decision shall be published once each week for three consecutive weeks in a newspaper of general circulation, published or circulated in the county of last-known residence of the respondent.
- e. If the respondent or applicant is represented by an attorney, the final decision shall be mailed to the attorney. The attorney may waive the requirement to serve the respondent or applicant through a written acknowledgment that the attorney is accepting service on behalf of the client. The state shall be served by first-class mail or state interoffice mail.

**20.31(4)** A final decision is a permanent public record open for inspection under Iowa Code chapter 22, in accordance with Iowa Code section 272C.6(4).

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.32(17A,272C) Applications for rehearing.**

**20.32(1) Who may file.** Any party to a contested case proceeding may file an application for rehearing from a final order.

**20.32(2) Content of application.** An application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the board decision on the existing record and whether, upon showing good cause, the applicant requests an opportunity to submit additional evidence. A party may request the taking of additional evidence after the issuance of a final order only by establishing that:

- a. The evidence is material; and
- b. The evidence arose after the completion of the original hearing; or
- c. Good cause exists for failure to present the evidence at the original hearing; and
- d. The party has not waived the right to present additional evidence.

**20.32(3) Time of filing.** The application shall be filed with the board office within 20 days after issuance of the final decision.

**20.32(4) Notice to other parties.** A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

**20.32(5) Disposition.** Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

**20.32(6) *Only remedy.*** Application for rehearing is the only procedure by which a party may request that the board reconsider a final board decision.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.33(17A,272C) Stays of agency actions.**

**20.33(1) *When available.*** Any party to a contested case proceeding may petition the board for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the board or pending judicial review. The petition shall state the reasons justifying a stay or other temporary remedy. The petition must be filed within 30 days of the issuance of the final order, or if a party filed a request for rehearing that was denied, the petition must be filed within 30 days after the request for rehearing was denied or deemed denied.

**20.33(2) *When granted.*** The board shall not grant a stay in any case in which the district court would be expressly prohibited by statute from granting a stay. In determining whether to grant a stay, the presiding officer shall consider the following factors:

- a. The extent to which the applicant is likely to prevail when the board or court finally disposes of the matter;
- b. The extent to which the applicant will suffer irreparable injury if relief is not granted;
- c. The extent to which the grant of relief to the applicant will substantially harm other parties to the proceedings;
- d. The extent to which the public interest relied on by the board is sufficient to justify the board's action in the circumstances.

**20.33(3) *Exhaustion required.*** A party must petition the board for a stay pursuant to this rule prior to requesting a stay from the district court in a judicial review proceeding.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.34(17A,272C) No factual dispute contested cases.** If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.35(17A,272C) Emergency adjudicative proceedings.**

**20.35(1) *Necessary emergency action.*** To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, the board 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 agency by emergency adjudicative order. Before issuing an emergency adjudicative order, the board shall consider factors including, but not limited to, the following:

- a. Whether there has been a 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; and
- e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

**20.35(2) Issuance.**

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

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

- (1) Personal service, as provided in the Iowa Rules of Civil Procedure, or
- (2) Certified restricted mail, return receipt requested, or
- (3) Signed acknowledgment accepting service.

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

**20.35(3) Notice.** Unless the written emergency adjudicative order is served personally on the same day that the order issues, the board shall make reasonable immediate efforts to contact by telephone and electronic mail the persons who are required to comply with the order.

**20.35(4) Proceedings.** Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for hearing. After issuance of an emergency adjudicative order, the licensee subject to the emergency adjudicative order may request a continuance of the hearing at any time by filing a request with the board. The state may only file a request for a continuance in compelling circumstances. Nothing in this subrule shall be construed to eliminate the opportunity to resolve the matter with a settlement agreement.

**20.35(5) Public record.** An emergency adjudicative order is a permanent public record open for inspection under Iowa Code chapter 22.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.36(17A,147,272C) Application for reinstatement.** Any person whose license to practice nursing has been revoked or has been voluntarily surrendered may apply for reinstatement. An application for reinstatement must be made in accordance with the terms specified in the board's order of revocation or order accepting the voluntary surrender. Any person whose license to practice nursing has been suspended and the board order imposing the suspension indicates that the respondent must apply for and receive reinstatement may apply for reinstatement in accordance with the terms specified in the board's order. All applications for reinstatement must be filed in accordance with this rule.

**20.36(1)** If the order for revocation, suspension, or surrender did not establish terms for reinstatement, an initial application for reinstatement may not be filed until at least one year has elapsed from the date of issuance of the order. Persons who have failed to satisfy the terms imposed by the board order revoking, suspending, or surrendering a license shall not be entitled to apply for reinstatement.

**20.36(2)** Reinstatement proceedings shall be initiated by the respondent, who shall file with the board an application for reinstatement of the respondent's license. Such application shall be docketed in the original contested case in which the license was revoked, suspended, or surrendered. The person filing the application for reinstatement shall immediately serve a copy upon the office of the attorney general and shall serve any additional documents filed in connection with the application.

**20.36(3)** The application shall allege facts and circumstances which, if established, will be sufficient to enable the board to determine that the basis for the revocation, suspension, or surrender no longer exists and that it shall be in the public interest for the license to be reinstated. The application shall include written evidence supporting the respondent's assertion that the basis for the revocation, suspension, or surrender no longer exists and that it shall be in the public interest for the license to be reinstated. Such evidence may include, but is not limited to: medical and mental health records establishing successful completion of any necessary medical or mental health treatment and aftercare recommendations; documentation verifying successful completion of any court-imposed terms of probation; statements from support group sponsors verifying active participation in a support group; verified statements from current and past employers attesting to employability; and evidence establishing that prior professional competency or unethical conduct issues have been resolved. The burden of proof to establish such facts shall be on the respondent.

**20.36(4)** The executive director or designee shall review the application for reinstatement and determine if it conforms to the terms established in the board order that revoked, suspended, or surrendered the license and the requirements imposed by this rule. Applications failing to comply with the specified terms or with the requirements in this rule will be denied. Such denial shall be in writing, stating the grounds, and may be appealed by requesting a hearing before the board.

**20.36(5)** Applications not denied for failure to conform to the terms established in the board order that revoked, suspended, or surrendered the license or requirements imposed by this rule may be set for hearing before the board. The hearing shall be a contested case hearing within the meaning of Iowa Code section 17A.12, and the order to grant or deny reinstatement shall incorporate findings of fact and conclusions of law. If reinstatement is granted, terms may be imposed. Nothing shall prohibit the board from entering into a stipulated order granting reinstatement with or without terms in the absence of a hearing.

**20.36(6)** A nurse whose license is reinstated must complete the requirements for license reactivation in order to receive an active license.

**20.36(7)** An order granting or denying reinstatement is a permanent public record open for inspection under Iowa Code chapter 22.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.37(17A,22,272C) Dissemination of public records.** All documents identified in this chapter as permanent public records open for inspection under Iowa Code chapter 22 are reported to NURSYS® and national databanks in accordance with applicable reporting requirements. In addition, these documents may be posted on the board's Web site, published in the board's newsletter, distributed to national or state associations, transmitted to mailing lists or news media, issued in conjunction with a press release, or otherwise disseminated.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

**655—20.38(17A) Judicial review.** Judicial review of a final order of the board may be sought in accordance with the terms of Iowa Code chapter 17A.

[ARC 2339C, IAB 1/6/16, effective 2/10/16]

These rules are intended to implement Iowa Code chapters 17A, 147, 152, 152E and 272C.

[Filed ARC 2339C (Notice ARC 2109C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]



## **PUBLIC SAFETY DEPARTMENT[661]**

Rules transferred from agency number 680 to 661 to conform with the reorganization numbering scheme in general

### CHAPTER 1 THE DEPARTMENT

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### CHAPTER 3 SHERIFF'S UNIFORMS

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**661—87.1(34A) Wireless communications service provider database established.** The wireless communications service provider database is established in the department of public safety. All wireless communications service providers authorized to do business in the state of Iowa, or submitting to the jurisdiction of the state of Iowa, shall submit current contact information to the department of public safety in order to facilitate requests from law enforcement agencies and public safety answering points (PSAPs), so that law enforcement agencies and PSAPs can promptly obtain location information concerning a cell phone or other wireless communications device in emergency situations.

[ARC 2335C, IAB 1/6/16, effective 2/10/16]

**661—87.2(34A) Definitions.** The following definitions apply to rules 661—87.1(34A) through 661—87.6(34A):

“*Department*” means the Iowa department of public safety.

“*Public safety answering point*” or “*PSAP*” means the same as defined in Iowa Code section 34A.2(16).

[ARC 2335C, IAB 1/6/16, effective 2/10/16]

**661—87.3(34A) Administration of database.** The database is administered by the division of intelligence within the department. The information in the database shall only be available to law enforcement agencies and PSAPs and only as authorized in Iowa Code section 34A.16 and these rules.

[ARC 2335C, IAB 1/6/16, effective 2/10/16]

**661—87.4(34A) Confidentiality.** All information and records in the wireless communications service provider database maintained by the department and all inquiries and results of inquiries to the service providers are confidential records pursuant to Iowa Code section 22.7(5) and chapter 692 and any other applicable federal or state laws or rules.

[ARC 2335C, IAB 1/6/16, effective 2/10/16]

**661—87.5(34A) Database requirements.**

**87.5(1)** A wireless communications service provider shall provide the following information for the database:

- a. Company name of the provider;
- b. Physical address;
- c. Mailing address;
- d. Name of the point of contact for the provider;
- e. Phone number and alternate phone number for the point of contact, which will be answered 24 hours a day, 7 days a week, by a person or persons who can promptly provide the location information of the cell phone or other wireless communications device upon the request of the department or other law enforcement agency or PSAP;
- f. Fax number; and
- g. E-mail address.

**87.5(2)** Each wireless communications service provider shall immediately provide the department with any updates or changes to the information required in 87.5(1). On or before June 15 of each year, each wireless communications service provider shall confirm to the department the provider’s information for the database.

**87.5(3)** The information required in 87.5(1) shall be submitted to the department by at least one of the following:

- a. E-mail: [intinfo@dps.state.ia.us](mailto:intinfo@dps.state.ia.us).
- b. Fax: (515)725-6320, Attn: Division of Intelligence, Subject: Wireless Communications Provider contact information.

c. U.S. mail: Iowa Department of Public Safety, Division of Intelligence, Oran Pape Building, 215 East 7th Street, Des Moines, Iowa 50319-0049.  
[ARC 2335C, IAB 1/6/16, effective 2/10/16]

**661—87.6(34A) Procedures to request provider information.** Upon a determination by a law enforcement agency or PSAP that emergency location information for a subscriber's cell phone or other wireless communications device is required, the law enforcement agency or PSAP shall contact Iowa state patrol communications to request the contact information for the wireless communications systems provider.

[ARC 2335C, IAB 1/6/16, effective 2/10/16]

These rules are intended to implement Iowa Code section 34A.16.

[Filed ARC 2335C (Notice ARC 2170C, IAB 9/30/15), IAB 1/6/16, effective 2/10/16]

## REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, Chapter 1245.

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CHAPTER 15  
DETERMINATION OF A SALE AND SALE PRICE  
[Prior to 12/17/86, Revenue Department[730]]

**701—15.1(422) Conditional sales to be included in gross sales.** When a conditional sale agreement exists the seller shall bill the purchaser for the full amount of tax due. The purchaser is obligated to pay sales tax upon delivery of the property which is the subject of the conditional sale agreement. *Harold D. Sturtz v. Iowa Department of Revenue*, 373 N.W.2d 131 (Iowa 1985). The gross receipts shall be computed on the entire contract price except interest and finance charges when separately stated and reasonable in amount, and the seller shall remit the tax to the department at the close of the period during which delivery under the contract for the sale was made.

This rule is intended to implement Iowa Code sections 422.42(2) and 422.42(3).

**701—15.2(422,423) Repossessed goods.** When tangible personal property which has been repossessed either by the original seller or by a finance company is resold to final users or consumers, the gross receipts from those sales are subject to tax.

A retailer repossessing previously sold merchandise shall be entitled to claim a credit on tax paid for bad debts in the same fashion as any other retailer who has paid tax to the department upon gross receipts which ultimately constitute bad debts. See rule 15.4(422,423) for a description of the circumstances under which bad debts are and are not allowed as a credit on tax paid.

This rule is intended to implement Iowa Code sections 422.42, 422.43, 423.1, and 423.2.

**701—15.3(422,423) Exemption certificates, direct pay permits, fuel used in processing, and beer and wine wholesalers.**

**15.3(1) General provision.** The gross receipts from the sale of tangible personal property to a purchaser for any exempt purpose are not subject to tax as provided by the Iowa sales and use tax statutes. In addition, a seller of tangible personal property need not collect Iowa sales or use tax from a purchaser that possesses a valid direct pay permit issued by the department of revenue. However, the following are requirements for the exemption and noncollection of tax by a seller when a direct pay permit is involved:

*a.* Prior to July 1, 2004, the sales tax liability for all sales of tangible personal property was upon the seller unless the seller took in good faith from the purchaser a valid exemption certificate stating that the purchase was for an exempt purpose or the tax would be remitted directly to the department by the purchaser under a valid direct pay permit issued by the department. In addition to the provisions and requirements set forth in subrule 15.3(2), to be valid an exemption certificate issued by a purchaser to a seller in good faith under a direct pay permit must have included the purchaser's name, direct pay permit number, and date the direct pay permit was issued by the department. A seller who has taken a valid exemption certificate under a direct pay permit must keep records of sales made in accordance with rule 701—11.4(422,423). For more information regarding direct pay permits, see rule 701—12.3(422). Where tangible personal property or services have been purchased tax-free pursuant to a valid exemption certificate which was taken in good faith by the seller, and the tangible personal property or services were used or disposed of by the purchaser in a nonexempt manner, or the purchaser failed to pay tax to the department under a direct pay permit issued by the department, the purchaser was solely liable for the taxes and must remit the taxes directly to the department.

When a processor or fabricator purchases tangible personal property exempt from the sales or use tax and subsequently withdraws the tangible personal property from inventory for its own taxable use or consumption, the tax shall be reported in the period when the tangible personal property was withdrawn from inventory.

*b.* As of July 1, 2004, the requirement of "good faith" on the part of a seller is replaced by a different standard. For sales occurring on and after that date, the sales tax liability for all sales of tangible personal property and all sales of services is upon the seller and the purchaser unless the seller takes from the purchaser a valid exemption certificate stating under penalty of perjury that the purchase is for

a nontaxable purpose and is not a retail sale, or the seller is not obligated to collect tax due, or unless the seller takes a fuel exemption certificate. If the tangible personal property or services are purchased tax-free pursuant to a valid exemption certificate and the tangible personal property or services are used or disposed of by the purchaser in a nonexempt manner, the purchaser is solely liable for the taxes and shall remit the taxes directly to the department. The protection afforded a seller by this paragraph does not apply to a seller who fraudulently fails to collect tax or to a seller who solicits purchasers to participate in the unlawful claiming of an exemption.

c. The director is required to provide exemption certificates to assist retailers in properly accounting for nontaxable sales of tangible personal property or services to buyers for exempt purposes. These exemption certificates must be completed as to the information required on the form in order to be valid.

**15.3(2) Retailer-provided exemption certificates.** Retailers may provide their own exemption certificates. Those exemption certificates must contain information required by the department, including, but not limited to: the seller's name, the buyer's name and address, the buyer's nature of business (wholesaler, retailer, manufacturer, lessor, other), the reason for purchasing tax-exempt (e.g., resale or processing), the general description of the products purchased, and state sales tax or I.D. registration number. The certificate must be signed and dated by the buyer.

a. An exemption certificate or blanket exemption certificate as referred to in paragraph "b" cannot be used to make a tax-free purchase of any tangible personal property or service not covered by the certificate. For example, the certificate used to purchase a chemical consumed in processing cannot be used to purchase a generator which is going to become an integral part of other tangible personal property which will be ultimately sold at retail.

b. Any person repeatedly selling the same type of property or service to the same purchaser for resale, processing, or for any other exempt purpose may accept a blanket certificate covering more than one transaction. A seller who accepts a blanket certificate is required periodically to inquire of the purchaser to determine if the information on the blanket certificate is accurate and complete. Such an inquiry by the seller shall be deemed evidence of good faith on the part of the seller.

c. When due to extraordinary circumstances in the nature of fire, flood, or other cases of destruction beyond the taxpayer's control, a seller does not have an exemption certificate on file, the seller may show by other evidence, such as a signed affidavit by the purchaser, that the property or service was purchased for an exempt purpose.

d. The liability for the tax does not shift from the seller to the purchaser if the seller has not accepted a valid exemption certificate in good faith. If the seller has actual knowledge of information or circumstances indicating that it is unlikely that the property or services will be used by the purchaser in an exempt manner, then in order to act in good faith the seller must make further inquiry to determine the facts supporting the exemption certificate. In addition, if the nature of the business of the purchaser, as shown by the exemption certificate, indicates that it is unlikely that the property or services will be used in an exempt manner, then in order to act in good faith the seller must make further inquiry to determine the facts supporting the exemption certificate.

EXAMPLE 1. A seller is expected to inquire to discover the facts supporting the claimed exemption if the seller knows that the property or services will not be, or it is unlikely that the property or services will be, resold or used in processing by that purchaser. This further inquiry is expected even when there is nothing in the nature of the business as shown on the valid exemption certificate to cause the seller to make further inquiry.

EXAMPLE 2. A seller is expected to inquire to discover the facts supporting the claimed exemption of the sale of sawdust or a tool chest purchased by a gas station since such items are rarely resold by a gas station.

EXAMPLE 3. A seller is not expected to make further inquiry, in the absence of actual knowledge, to determine which light bulbs bought by a hardware store are for use in the store or those purchased for resale.

If the seller has met the requirements set forth above in accepting a valid exemption certificate, the seller shall be deemed to have acted in good faith and the liability for the tax shifts to the purchaser who becomes solely liable for the taxes.

*e.* A seller is relieved from liability for sales tax if (1) a purchaser deletes the tax reimbursement from the payment to the seller or if the purchaser makes a notation on an invoice such as “not subject to tax” or “resale” and (2) if the seller can produce written evidence to show that an attempt was made to obtain an exemption certificate to show that the transaction was exempt from tax but was unable to obtain said certificate from the purchaser.

*f.* The failure of a permit holder to act in good faith while giving or receiving exemption certificates may result in the revocation of the sales tax permit. Revocation is authorized under the provisions of Iowa Code section 422.53(5).

*g.* The purchase of tangible personal property or services which are specifically exempt from tax under the Iowa Code need not be evidenced by an exemption certificate. However, if certificates are given to support these transactions, they do not relieve the seller of the responsibility for tax if at some later time the transaction is determined to be taxable.

*h.* A person who is selling tangible personal property or services, but who is not making taxable sales at retail, shall not be required to hold a permit. When this person purchases tangible personal property or services for resale, the person shall furnish a certificate in accordance with these rules to the supplier stating that the property or services was purchased for the purpose of resale.

*i.* For information regarding the use of exemption certificates for contractors, see 701—Chapter 19.

**15.3(3) Fuel exemption certificates.**

*a.* Definitions.

“*Fuel*” includes, but is not limited to, heat, steam, electricity, gas, water, or any other tangible personal property consumed in creating heat, power, or steam.

“*Fuel consumed in processing*” includes fuel used in grain drying or providing heat or cooling for livestock buildings, fuel used for generating electric current, fuel consumed in implements of husbandry engaged in agricultural production, as well as fuel used in “processing” as defined in rules 701—18.29(422,423), 701—18.58(422,423), and 701—230.15(423). See rule 701—17.2(422) for a detailed description of “fuel used in processing.” See rule 701—17.3(422,423) for extensive discussion regarding electricity and steam used in processing.

“*Fuel exemption certificate*” is a certificate given by a purchaser and signed under penalty of perjury to assist a seller in properly accounting for nontaxable sales of fuel consumed in processing. The fuel exemption certificate must contain information required by the department, including, but not limited to: the seller’s name and address; the purchaser’s name and address; the type of fuel purchased, e.g., electricity, propane; a description of the purchaser’s business, e.g., farmer, manufacturer of steel products, food processor; a general description of the type of processing in which the fuel is consumed, e.g., grain drying, raising livestock, generating electricity, or manufacture of tangible personal property; and the percentage exemption claimed. The fuel exemption certificate must be signed under penalty of perjury by the purchaser and dated. The seller may demand from the purchaser additional documentation attached to the fuel exemption certificate which is reasonably necessary to support the claim of exemption for fuel consumed in processing. In the absence of separate metering, documentation reasonably necessary to support a claim for exemption will consist of either an electrical consultant’s survey or of a document prepared by the purchaser in accordance with the requirements of subrule 15.3(4). Attachment of documentation is not necessary if the purchaser has furnished the seller with documentation when filing an earlier exemption certificate and a substantial change in the purchaser’s operation had not occurred since the documentation was furnished or if fuel consumed by the purchaser in processing is separately metered and billed by the seller.

“*Substantial change*” means a change in the purchaser’s use or disposition of tangible personal property and services such that the purchaser pays less than 90 percent of the purchaser’s actual sales tax liability.

b. If fuel is purchased tax-free pursuant to a fuel exemption certificate which has been accepted by the seller and the purchaser uses or disposes of the fuel in a nonexempt manner, the purchaser is solely liable for sales tax and shall remit that tax directly to the department. A seller can, however, rely upon a fuel exemption certificate for sales occurring within five years subsequent to the date of the certificate only. For later sales, the seller must secure a new certificate of exemption from the purchaser.

c. A purchaser may apply to the department for review of any fuel exemption certificate. The department shall review the certificate and determine the correct amount of exemption within 12 months from the date of application. The department shall notify a purchaser of any determination that is different from the purchaser's claim of exemption. Failure to determine the correct amount of exemption within 12 months from the date of application shall constitute a determination on the department's part that the claim of exemption on the fuel certificate is correct as submitted. A determination regarding an exemption certificate is final unless the purchaser appeals to the director for a revision of the determination within 60 days from the date of the notice of determination. The director shall grant a hearing and upon the hearing, the director shall determine the correct exemption and notify the purchaser of the decision by mail. The decision is final unless the purchaser seeks judicial review of the director's decision under Iowa Code section 422.55 within 60 days from the date of the notice of the director's decision. The purchaser must notify the seller of any change in percentage.

d. The effective date of the legislation allowing use of an exemption certificate for fuel used in processing is January 1, 1988. However, a certificate which is complete and correct according to subrule 15.3(3), paragraph "a," and any other requirement of the director, which is signed and dated prior to January 1, 1988, shall, if accepted by a seller in good faith, protect the seller to the extent described in subrule 15.3(3), paragraph "b," for energy consumed on or after January 1, 1988. Exemption certificates filed with the seller prior to January 1, 1988, also expire five years from date of acceptance.

**15.3(4) *Determining percentage of electricity used in processing.*** When electricity is purchased for consumption both for processing and for taxable uses, and the use of the electricity is recorded on a single meter, the purchaser must allocate the use of the electricity according to taxable and nontaxable consumption if an exemption for nontaxable use is to be claimed. The calculations which support the allocation, if properly performed, can serve as the documentation reasonably necessary to support a claim of exemption for fuel used in processing. The following method with its alternative table may be used to determine the percentage of electricity used on the farm or in a factory which is exempt by virtue of its being used in processing. See subrule 15.3(4), paragraph "e," for alternative methods of computing exempt use, including exempt use by a new business. First, the base period for the calculations must be selected.

a. Ordinarily, the 12 months previous to the date upon which the exemption is calculated are used as the base period for determining the percentage of electricity exempt as used in processing. This immediately previous 12-month period is used because it is a span of time which is (1) recent enough to accurately reflect future electric usage; (2) extended enough to take into account variations in electrical usage resulting from changes in temperature occurring with the seasons; and (3) is not so long as to require unduly burdensome calculations. However, individual circumstances can dictate that a shorter or longer period than 12 months will be used or that some 12-month period other than that immediately previous to the date upon which the exemption certificate is filed, will be used.

EXAMPLE: Mr. Wilson is a farmer. He files an exemption certificate for the period beginning January 1, 1990. The year 1989 is one with a very mild winter, a relatively cool summer, and a very dry autumn. Mr. Wilson uses no electricity for grain drying and substantially less electricity than usual for heating and cooling his livestock buildings. Mr. Wilson must use a 12-month period which is more representative of his usual exempt electrical consumption than that of January through December 1989.

EXAMPLE: Mr. Jackson is also a farmer. He files an exemption certificate for the period beginning January 1, 1991. The year 1990 is one in which the summer is extraordinarily hot, the winter exceedingly cold, and the autumn very wet. Mr. Jackson uses far more electricity than normal to dry his grain and heat and cool his livestock buildings. He should use a 12-month period more representative of his customary exempt use of electricity than the period January through December 1990.

EXAMPLE: Company A manufactures its product in a factory which has no windows and is heavily insulated. The factory always runs 40 hours per week, 52 weeks per year. Because of these and other circumstances, Company A's electrical usage does not vary significantly from month to month, and it is easy enough to document this. Company A can calculate its percentage of exempt use of electricity based on a one-month, rather than a 12-month, period.

EXAMPLE: Company B manufactures widgets. The "economic cycle" for widget production is, on the average, 36 months long. During this economic cycle, there are times when, for months at a time, the factory will operate three shifts. At other times, for weeks at a time, the entire factory will be shut down and its personnel laid off. The only accurate way to determine exempt percentage of electricity used is to calculate electrical use over the entire economic cycle. Therefore, 36 months, rather than 12 months, would be the base period.

*b.* Calculating kilowatts used per hour by various electrical devices. The first step in computing percentage of exemption is to determine the number of kilowatts used per hour for each device in farm or factory. If kilowatts consumed per hour of a device's use is not listed on the device or otherwise readily obtainable, formulas can be used to determine this information.

#### Lights

For incandescent bulbs, add rated wattages and divide by 1,000. For fluorescent lights, add rated wattages plus an additional 20 percent of rated wattages, then divide by 1,000.

#### Incandescent Lights:

$$\frac{\text{Watts}}{1,000} = \text{Kilowatts Per Hour}$$

#### Fluorescent and Other High Intensity Lights:

$$\frac{\text{Watts} + .20 (\text{Watts})}{1,000} = \text{Kilowatts Per Hour}$$

#### Devices Other Than Lights

For these devices, use the wattage rating given by the manufacturer and divide by 1,000 to obtain approximate kilowatts used per hour of operation.

$$\frac{\text{Watts}}{1,000} = \text{Kilowatts Per Hour}$$

If an appliance does not list a watt rating, tables provided by Iowa State University Cooperative Extension Service can be used especially by farmers who are attempting to compute their exempt percentage of electricity used. Persons using a table are reminded to convert watts to kilowatts before proceeding to further calculations.

*c.* The average number of kilowatts consumed per hour of operation for any one device must next be multiplied by the total number of hours which the device is operated during the base period. A person may use intermediate calculations. For example, assume that a machine used in processing consumes 20 kilowatts per hour of operation. The machine is operated, during a 12-month base period, 40 hours per week during 50 weeks. The machine is not placed in operation when the factory is closed for two weeks vacation. Exempt use is calculated as follows:

$$\frac{\text{Kilowatts Per Hour}}{20} \times \frac{\text{Hours Operated Per Week}}{40} \times \frac{\text{Weeks Operated in 12-Month Period Equals Number of Exempt Kilowatt Hours}}{50} = 40000$$

Assume that a grain dryer uses 30 kilowatts per hour of operation. During a 12-month base period, the grain dryer is used in processing 200 hours per month, for 3 months. The calculation for total number of kilowatt hours of exempt use for the 12-month period is as follows:

$$\frac{\text{Kilowatts Per Hour}}{30} \times \frac{\text{Hours of Exempt Use Per Month}}{200} \times \frac{\text{Number of Months of Exempt Use Equals Total Number of Exempt Kilowatt Hours}}{3} = 18000$$

d. The following is a very simplified example of a worksheet for determining the percentage of electricity qualifying for exemption when a single meter records both exempt and taxable use.

	Kilowatts Per Hour of Operation	Average Hours of Operation Per 12-Month Base Period	Average Kilowatt Hours Per 12-Month Base Period	Total
All Exempt Usage				
Production Machine #1	10	1000	10000	
Production Machine #2	10	1000	10000	
Other	10	1000	10000	
Total Exempt Usage				30000(A)
All Taxable Usage				
Air Conditioners	10	3000	30000	
General Lighting	10	3000	30000	
Office Equipment	10	3000	30000	
Space Heaters	10	3000	30000	
Other	10	3000	30000	
Total Taxable Usage				150000(B)
Total—All Usages				180000(C)

$$\frac{30000}{180000} \text{ or } \frac{A}{C} = \text{Percentage of Electricity Purchase Qualifying for Exemption} = 16.60\%$$

The number actually used in the base period can be determined by reference to billings for the base period. If the number of kilowatt hours calculated to have been used does not approximate the number actually used in the base period, the calculations are deficient and should be performed again. Once the precise percentage of exemption has been calculated, that percentage must be applied during any period for which a purchaser is requesting exemption. Any substantial and permanent change in the amount of electricity consumed or in the proportion of exempt and nonexempt use of electricity is an occasion for recomputing the exempt percentage and for filing a new exemption certificate.

e. The following are nonexclusive alternatives to the above method of determining the percentage of electricity which is exempt because it is used in processing. First, if currently only one meter exists to measure both exempt and nonexempt use of electricity, the most accurate method of determining exempt and nonexempt use may be separate metering of these two uses. This possibility is especially practical

if all exempt use results from the activities of one machine, however large. If separate metering is impossible or impractical, it may be useful to employ the services of an energy consultant. If using energy consultant's service is impractical, it may be possible to secure, from the manufacturer of a machine used in processing, the number of kilowatts which a machine uses per hour of operation. Often, these manufacturer's studies give a more accurate measure of a machine's use of electricity than the formulas set out in paragraph 15.3(4) "b" above. This circumstance is especially true with regard to large electric motors.

If a business is new, and no historical data exists for use in calculating exempt and nonexempt percentages of electricity or other fuel consumed, any person calculating future exempt use must make the best projections possible. If calculating future exempt use with no past historical data to serve as a basis for the calculations, it is suggested that conservative estimates of exempt use be made. Using these conservative estimates can avoid future liability for sales tax on the part of the purchaser of the electricity. Possibly, in calculating exempt use of fuel for a new business, historical data from existing similar businesses can be used if available from persons not in direct competition to the person claiming the exemption.

Ordinarily any method of determining the percentage of electricity used in processing will involve calculating both exempt and nonexempt usage. However, in certain instances it is acceptable to calculate only exempt or nonexempt usage in one column and to list separately the equipment or devices making the exempt or nonexempt use of the electricity separate. This practice can normally be followed where electrical usage does not fluctuate dramatically and where usage is either predominantly exempt or predominantly not exempt.

**15.3(5) *Applicability.*** The provisions of subrule 15.3(4) explaining the determination of the percentage exemption for electricity also apply to other types of fuel such as natural gas, LP, etc., when used for exempt purposes.

**15.3(6) *Special certificates of beer and wine wholesalers.*** Beer or wine purchased from a wholesaler holding a Class A or F permit has been purchased for resale if the purchaser provides the wholesaler with a retail beer or wine permit or liquor license number. A wholesaler's record of account with an individual retailer is a complete and correct exemption certificate for the purposes of beer or wine sales and provides all the protection which the usual exemption certificate (see subrule 15.3(2)) provides if the record of account contains the retailer's beer or wine permit or liquor license number and all other information concerning the account is taken in good faith by the wholesaler. The words "beer," "permit," "retailer," "wholesaler," and "wine" have the same definitions for the purposes of this rule as the definitions given them in Iowa Code section 123.3.

This rule is intended to implement Iowa Code sections 422.42(3), 422.42(13), 422.42(16), 422.47, 422.53 as amended by 1997 Iowa Acts, House File 266, and 423.1(1).

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—15.4(422,423) Bad debts.** Bad debts shall be allowed as a credit on tax when all the following facts have been shown:

**15.4(1)** Tax has been previously paid on the gross receipts from the accounts on which the taxpayer claims credit for tax.

**15.4(2)** The accounts have been found to be worthless.

**15.4(3)** The taxpayer has records to show that the accounts have actually been charged off for income tax purposes.

Credit for bad debts shall not be allowed on merchandise which was exempt from tax when sold.

When credit on tax has been taken on account of bad debts and the debts are subsequently paid, the proceeds from the collection of such accounts shall be included in the gross receipts for the period in which payment is made.

Effective July 1, 1992, the sales and use tax rate increased from 4 percent to 5 percent.

Bad debts which occur prior to July 1, 1992, and are charged off on or after July 1, 1992, may be charged off at the tax rate of 5 percent. Bad debts which have been charged off prior to July 1, 1992,

and all or any part of the bad debt is recovered after July 1, 1992, will be subject to tax at the rate of 5 percent. All the provisions of this rule and rule 15.5(422,423) apply.

This rule is intended to implement Iowa Code sections 422.42(16), 422.46, and 423.1(10).

**701—15.5(422,423) Recovery of bad debts by collection agency or attorney.** When bad debts have been charged off and later recovered in whole, or in part, through the services of a collection agency or an attorney, the full amount of the debt recovered shall be included with the gross sales for the period which the collection was made. The services of an agency or attorney are services purchased by a retailer and shall not reduce the gross amount collected for the retailer by the agency or attorney.

This rule is intended to implement Iowa Code sections 422.42(16), 422.46, and 423.1(10).

**701—15.6(422,423) Discounts, rebates and coupons.**

**15.6(1) Discounts.** A discount is an abatement from the face of an account, with the remainder being the actual purchase price of the goods charged in the account. The purchaser entitled to the discount will never owe the face of the bill as a debt—this being the net of the bill after the agreed discount has been deducted. The word “discount” means “to buy at a reduction.” *Benner Tea Company v. Iowa State Tax Commission*, 252 Iowa 843, 109 N.W.2d 39 (1961).

Any discount allowed by a retailer and taken on taxable sales is a proper deduction when collecting and reporting tax. This is not the case when the retailer offers a discount to a purchaser but bills and collects tax on the gross charge rather than on the net charge. The customer must receive the benefit of the discount, for sales tax purposes, in order for the retailer to exclude it from gross receipts.

Certain retailers bill their customers on a gross and net basis, with the difference considered to be a discount for payment purposes. When a customer does not resolve the bill within the net payment period, tax shall apply on the gross charge shown on the billing.

**15.6(2) Rebates.** A rebate is a return of part of an amount paid for a product. Manufacturers’ rebates are not discounts and cannot be used to reduce the gross receipts received from a sale or reduce the purchase price of a product. This rule applies even though the rebate is used by the seller to reduce the selling price or is used by the purchaser as a down payment. The rebate is considered a transaction between the manufacturer and the purchaser. See 1972 O.A.G. 332.

**15.6(3) Coupons.** Coupons issued by the producer of a product are not discounts and cannot be used as an abatement from the face of the account. Coupons issued by the retailer which actually reduce the price of the product to the purchaser are treated as a discount as per subrule 15.6(1). *Saxon-Western Corporation v. Mahin*, 369 N.E.2d 1185 (Ill. 1979).

EXAMPLE: C acquires a 30¢ off coupon issued by manufacturer of A-B Band-aids for A-B Band-aids which can be redeemed at a store which sells the product. C goes to store D and purchases a box of A-B Band-aids which shows a price of \$1.50. C pays \$1.20 + the 30¢ coupon. D is reimbursed the 30¢ for the coupon by the manufacturer. Tax is due on the \$1.50 because C’s total gross receipts are \$1.50. The coupon is not used as a discount in this situation.

EXAMPLE: E offers a two for the price of one coupon for its super hamburger. Each hamburger normally sells for \$2.00 each. The coupon can only be redeemed at E’s retail store. F acquires the coupon and redeems it at E’s store. The purchase price for F was \$2.00 for both hamburgers. The tax is due on the \$2.00 because this amount is the gross receipts for E, even though the value of the two hamburgers would normally be \$4.00. In this situation, the sales price for the two hamburgers was \$2.00.

This rule is intended to implement Iowa Code sections 422.42(6) and 423.1(3).

**701—15.7(422,423) Trading stamps are not a discount.** Rescinded IAB 11/14/01, effective 12/19/01.

**701—15.8(422,423) Returned merchandise.** When merchandise is sold and returned by a customer who secures an allowance or a return of the full purchase price, the seller may deduct the amount allowed as full credit or refund, provided the merchandise is taxable merchandise and tax has been previously paid on the gross receipts.

An allowance shall not be made for the return of any merchandise which (1) is exempt from either sales or use tax; or (2) has not been reported in the taxpayer's gross receipts and tax previously paid.

This rule is intended to implement Iowa Code sections 422.42(6) and 423.1(3).

**701—15.9(422) Goods damaged in transit.** If goods shipped by a retailer have been delivered under a contract for sale to a consumer, and thereafter the goods are damaged in the course of transit to the consumer, the retailer shall be liable for tax upon the full sale price of the goods, as the sale to the consumer has been completed. *Harold D. Sturtz v. Iowa Department of Revenue*, 373 N.W.2d 131 (Iowa 1985).

If the goods have not been delivered to the consumer, the sale to the consumer has not been completed, and the retailer shall not be taxed for the amount agreed to be paid by the consumer.

EXAMPLE: A company in Chicago transports furniture in its own truck to customer B in Des Moines. Under the contract of sale, delivery of the furniture would occur in Des Moines and sales tax would ordinarily be due upon the gross receipts of the sale. However, in East Moline, Illinois, the furniture truck is involved in an accident, and B's furniture is destroyed. There was no delivery of the furniture to B, thus no sale to B and thus no sales tax is due. Had the point of delivery been Chicago, Illinois, a sale would have occurred outside this state, but no use tax would be due because B never made any "use" of the furniture in Iowa.

This rule is intended to implement Iowa Code sections 422.42 and 422.43.

**701—15.10(422) Consignment sales.** When a retailer receives tangible personal property on consignment from others and the consigned merchandise is sold in the ordinary course of business with other merchandise owned or services performed by the retailer, the retailer or consignee shall be making sales at retail. In these cases, the consignee shall file a return and remit tax to the department along with the returns and remittances of gross receipts from the sale of other merchandise.

Sale of tangible personal property by an agent or consignee for another person shall be exempt if the sales meet the requirements of a casual sale or any other exemptions.

This rule is intended to implement Iowa Code sections 422.42 and 423.43.

**701—15.11(422,423) Leased departments.** When a permit holder leases a part of the premises where the permit holder's retail business is conducted, the lessor shall immediately notify the department and supply the following information: (1) name and home office address of the lessee; (2) type of merchandise sold by the lessee or service performed; (3) date when the lessee began making sales or performing services at retail in Iowa on the leased premises; and (4) whether the lessee has secured a permit to account directly to the department for tax due or if the lessee's sales will be accounted for in the lessor's tax return. Upon request, the department shall furnish a form to the lessor on which to report this information.

If the lessor fails to notify the department that a part of the premises has been leased and does not furnish the requested information, the lessor shall be responsible for tax due as a result of sales by the lessee, unless the lessee has properly remitted the tax due.

The lessor who has leased a part of the premises shall report to the department the names and addresses of all lessees. If the lessor is accounting for the lessee's sales, the lessor shall, after the name of each lessee, show the amount of net taxable sales made by the lessee and which net taxable sales are included in the lessor's return. If the lessee is reporting the tax directly to the department, the lessor shall show the permit number of the lessee.

When the lessee has terminated selling activities, the lessor shall immediately notify the department.

This rule is intended to implement Iowa Code sections 422.68(1) and 423.23.

**701—15.12(422,423) Excise tax included in and excluded from gross receipts.**

**15.12(1)** An excise tax which is not an Iowa sales or use tax may be excluded from the gross receipts or purchase price of the sale or use of property or taxable services only if all of the following conditions exist:

*a.* The excise tax is imposed upon the identical sale which the Iowa sales tax is imposed upon or upon the sale which measures the taxable use or upon a use identical to the Iowa taxable use and not upon some event or activity which precedes or occurs after the sale or use.

*b.* The legal incidence of the excise tax falls upon the purchaser who is responsible for payment of the Iowa sales tax. The purchaser must be obligated to pay the excise tax either directly to the government in question or to another person (e.g., the retailer) who acts as a collector of the tax. See *Gurley v. Rhoden*, 421 U.S. 200, 95 S. Ct. 1605, 44 L.Ed.2d 110 (1975) for a description of the circumstances under which the legal, as opposed to the economic, burden of an excise tax falls upon the purchaser.

*c.* The name of the tax is specifically stated and the amount of the tax separately set out on the invoice, bill of sale, or upon another document which embodies a record of the sale.

EXAMPLE 1. The federal government imposes an excise tax upon the act of manufacturing tangible personal property within the United States. The amount of the tax is measured as a percentage of the price for the first sale of the property, which is usually to a wholesaler. However, one particular manufacturer sells its manufactured goods at retail in Iowa. Even if this tax meets the requirements for exclusion of paragraphs “*b*” and “*c*” above, it is not excludable because it does not meet the requirements of paragraph “*a*.” The tax is not imposed upon the act of sale but upon the prior act of manufacture. The tax is merely measured by the amount of the proceeds of the sale.

EXAMPLE 2. The federal government imposes an excise tax of 4 percent on a retailer’s gross receipts from sales of tangible personal property. The law allows the retailer to separately identify and bill a customer for the tax. However, if a retailer fails to pay the tax, the government cannot collect it from a purchaser and if the government assesses tax against the retailer and secures a judgment requiring the retailer to pay the tax, the retailer who has failed to collect the tax from a purchaser on the initial sale has no right of reimbursement from the purchaser. This tax is not excludable from Iowa excise tax. Its economic burden falls upon the purchaser. However, since neither the government nor the retailer has any legal right to demand payment of the tax from a purchaser, the legal incidence of the tax is not upon the purchaser; and the tax would not meet the requirements of paragraph “*b*” above.

**15.12(2)** As of January 1, 1988, the following federal excise taxes are includable in the gross receipts of Iowa sales tax:

*a.* The federal gallonage taxes on distilled spirits, wines, and beer imposed by 26 U.S.C. Sections 5001, 5041, and 5051.

*b.* The tax imposed by 26 U.S.C. Section 5701 with regard to cigars, cigarettes, and cigarette papers and tubes.

*c.* The federal tax on gasoline imposed under 26 U.S.C. Section 4081.

*d.* The federal tax on tires, inner tubes, and tread rubber imposed by 26 U.S.C. Section 4071.

*e.* The federal manufacturer’s excise tax imposed by 26 U.S.C. Section 4061 has been repealed.

**15.12(3)** The following excise taxes are excluded from the amount of gross receipts:

*a.* The federal tax imposed by 26 U.S.C. Section 4251(a) on the communication services of local telephone service, toll telephone service, and teletypewriter exchange service.

*b.* The federal tax imposed by 26 U.S.C. Section 4051 upon the first retail sale of automobile and truck chassis and bodies; truck trailer and semitrailer chassis and bodies and tractors of the kind chiefly used for highway transportation in combination with trailers or semitrailers.

This rule is intended to implement Iowa Code sections 422.42(6), 422.43, 423.1, and 423.2.

**701—15.13(422,423) Freight, other transportation charges, and exclusions from the exemption applicable to these services.** The determination of whether freight and other transportation charges shall be subject to sales or use tax is dependent upon the terms of the sale agreement.

When tangible personal property or a taxable service is sold at retail in Iowa or purchased for use in Iowa and under the terms of the sale agreement the seller is to deliver the property to the buyer or the purchaser is responsible for delivery and such delivery charges are stated and agreed to in the sale agreement or the charges are separate from the sale agreement, the gross receipts derived from the freight or transportation charges shall not be subject to tax. As of May 20, 1999, this exemption does not apply

to the service of transporting electrical energy. As of April 1, 2000, this exemption does not apply to the service of transporting natural gas.

When freight and other transportation charges are not separately stated in the sale agreement or are not separately sold, the gross receipts from the freight or transportation charges become a part of the gross receipts from the sale of tangible personal property or a taxable service and are subject to tax. Where a sales agreement exists, the freight and other transportation charges are subject to tax unless the freight and other transportation charges are separately contracted. If the written contract contains no provisions separately itemizing such charge, tax is due on the full contract price with no deduction for transportation charge, regardless of whether or not such transportation charges are itemized separately on the invoice. *Clarion Ready Mixed Concrete Company v. Iowa State Tax Commission*, 252 Iowa 500, 107 N.W.2d 553(1961); *Schemmer v. Iowa State Tax Commission*, 254 Iowa 315, 117 N.W.2d 420(1962); *City of Ames v. Iowa State Tax Commission*, 246 Iowa 1016, 71 N.W.2d 15(1959); *Dain Mfg. Company v. Iowa State Tax Commission*, 237 Iowa 531, 22 N.W.2d 786(1946).

Effective July 1, 2001, gross receipts from charges for delivery of electricity or natural gas are exempt from tax to the extent that the gross receipts from the sale, furnishing, or service of electricity or natural gas or its use are exempt from sales or use tax under Iowa Code chapters 422 and 423.

The exclusions from this exemption relating to the transportation of natural gas and electricity are applicable to all contracts for the performance of these transportation services. Below are examples which explain some of the principal circumstances in which the transport of natural gas or electricity is a service subject to tax.

Freight and transportation charges include, but are not limited to, the following charges or fees: freight; transportation; shipping; delivery; or trip charges.

EXAMPLE 1. Consumer ABC, located in Des Moines, contracts with supplier DEF, located in Waterloo, for DEF to sell gas and electricity to ABC. ABC then contracts with utility GHI to transport the energy over GHI's network (of pipes or wires) from Waterloo to ABC's facility in Des Moines. GHI's transport of ABC's energy is a taxable service. The transportation of natural gas and electricity by a utility is a taxable service of furnishing natural gas or electricity whether or not that utility or some other utility produces the natural gas or generates the electricity furnished. A utility's transportation of gas or electricity is a "transportation service" specifically excluded from the exemption set out in this rule.

EXAMPLE 2. Consumer ABC contracts with utility DEF for DEF to provide electricity from DEF's generating plant in Mason City to ABC's location in Cedar Rapids. Transport of the electricity is by way of DEF's network of long distance transmission lines. The contract between ABC and DEF states the prices to be paid for the purchase of various amounts of electricity and also sets out the amounts to be paid for transport of electricity as well and constitutes separate sales of electricity and transportation services. In these circumstances, amounts which ABC pays DEF for transport of the electricity are taxable gross receipts. This transportation service would ordinarily then be excluded from tax under the exemption set out in this rule; however, separate transportation charges for transportation of electricity are excluded from the exemption (as of May 20, 1999, and are thereafter taxable).

EXAMPLE 3. As in Example 2, consumer ABC contracts with utility DEF for the delivery of electricity from DEF's generating plant in Mason City to ABC's location in Cedar Rapids, ownership of the electricity to pass to ABC in Cedar Rapids. Also, as in Example 2, the contract between ABC and DEF states varying prices to be paid for the purchase and transportation of varying amounts of electricity and constitutes separate sales of electricity and transportation services. Transport of the electricity will be by way of GHI's transmission lines. DEF contracts with GHI for the transport of the electricity to ABC's plant in Cedar Rapids. At the time the contract is signed, GHI asks DEF for an exemption certificate stating that DEF will resell GHI's transportation service to ABC. GHI must either secure the certificate or collect Iowa sales tax from DEF. GHI is furnishing a taxable electricity transportation service to DEF which DEF will in turn furnish to ABC. DEF must collect tax from ABC.

EXAMPLE 4. In this example, the same contract exists between ABC and DEF as exists in Example 3. However, in this example, a breakdown at DEF's plant in Mason City prevents DEF from generating the electricity which it is contractually obligated to provide to ABC. DEF is forced to purchase both

electricity and its transport from JKL. The contract between DEF and JKL states the prices to be paid for the purchase of various amounts of electricity and also sets out the amounts to be paid for the transport of this electricity as well and constitutes separate sales of electricity and transportation services. JKL asks DEF for an exemption certificate stating that DEF has purchased the electricity and its transport for resale to ABC. In this case, JKL must secure an exemption certificate from DEF to avoid collecting tax on its sale and transport of the electricity for DEF.

EXAMPLE 5. Again, ABC and DEF have contracted, as they did in Example 2, for DEF to sell and transport electricity from Mason City to Cedar Rapids. However, their agreement mentions only one combined price for sale and delivery of the electricity. There is no separately contracted price for transport of the electricity, in contrast to the situation in Example 2. In this case, the entire amount which ABC pays to DEF is taxable as the entire amount paid is for the sale of tangible personal property. See Clarion Ready Mixed and Schemmer, generally, above.

EXAMPLE 6. Manufacturer EFG contracts with utility DEF for the purchase of natural gas with a separate contract for its delivery. The gas is to be transported from DEF's storage facility near Osceola to EFG's manufacturing plant in Fort Dodge by way of DEF's pipeline. Ownership of the gas passes from DEF to EFG in Fort Dodge. EFG uses 92 percent of the gas which is transported to its plant in processing the goods manufactured there. The receipts which EFG pays DEF for the transport of the gas are excluded from the transportation exemption, but they are not excluded from the processing exemption. Ninety-two percent of those receipts are exempt from tax because that is the percentage of gas used by EFG in processing. In addition, utility DEF charges manufacturer EFG \$9.95 as a delivery fee for the gas. Since the purchase of the gas has a 92 percent exemption from Iowa sales tax because of a 92 percent usage in processing, 92 percent of the delivery charge of \$9.95 is also exempt from tax.

This rule is intended to implement Iowa Code sections 422.43 and 423.2, and section 422.45 as amended by 2001 Iowa Acts, House File 705.

**701—15.14(422,423) Installation charges when tangible personal property is sold at retail.** When the sale of tangible personal property includes a charge for installation of the personal property sold, the current rate of tax shall be measured on the entire gross receipts from the sale. The installation charges would not be taxable if: (1) The installation service is not an enumerated service, and also (2) where a sales agreement exists, the installation charges are separately contracted. If the written contract contains no provisions separately itemizing such charges, tax is due on the full contract price with no deduction for installation charges, regardless whether or not such installation charges are itemized separately on the invoice.

If the installation services are enumerated services, the installation charges would not be taxable if: (1) The services are exempt from tax, e.g., the services are performed on or connected with new construction, reconstruction, alteration, expansion or remodeling of a building or structure; or, the services are rendered in connection with the installation of new industrial machinery or equipment. See rule 701—19.13(422, 423) and subrule 18.45(7), respectively. And also (2) where a sales agreement exists, the installation charges are separately contracted. If the written contract contains no provisions separately itemizing such charges, tax is due on the full contract price with no deduction for installation charges, regardless whether or not such installation charges are itemized separately on the invoice. If no written contract exists, the installation charges must be separately itemized on the invoice to be exempt from tax.

This rule is intended to implement Iowa Code sections 422.43 and 423.2.

**701—15.15(422) Premiums and gifts.** A person who gives away or donates tangible personal property shall be deemed to be a consumer of such property for tax purposes. The gross receipts from the sale of tangible personal property to such persons for such purposes shall be subject to tax.

When a retailer purchases tangible personal property, exclusive of tax, for the purpose of resale in the regular course of business and later gives it away or donates it, the retailer shall include in the return the value of the property at the retailer's cost price.

When a retailer sells tangible personal property and furnishes a premium with the property sold, the retailer is considered to be the ultimate consumer or user of the premium furnished.

This rule is intended to implement Iowa Code sections 422.42 and 422.43.

**701—15.16(422)** **Gift certificates.** When a retailer sells gift certificates, tax shall be added at the time the gift certificate is redeemed.

This rule is intended to implement Iowa Code sections 422.42 and 422.43.

**701—15.17(422,423)** **Finance charge.** Interest or other types of additional charges that result from selling on credit or under installment contracts are not subject to sales tax when such charges are separately stated and when such charges are in addition to an established cash selling price. However, if a sale is made for a lump sum, the tax is due on the total selling price if finance charges are not separately stated.

When interest and other types of additional charges are added as a condition of a sale in order to obtain title rather than as a charge to obtain credit where title to goods has previously passed, such charges will be subject to tax even though they may be separately stated. *State ex. rel. Turner v. Younkers Bros., Inc.*, 210 N.W.2d 550 (Iowa 1973); *Road Machinery Supplies of Minneapolis, Inc., v. The Commissioner of Revenue*, Minnesota Tax Court of Appeals, 1977, 2 Minn. CCH State Tax Reporter II 200-835. See rule 701—16.47(422,423) relating to conditional sales contracts.

This rule is intended to implement Iowa Code sections 422.42(2) and 423.4.

**701—15.18(422,423)** **Coins and other currency exchanged at greater than face value.** Any exchange, transfer, or barter of merchandise for a consideration paid in gold, silver, or other coins or currency shall be subject to tax to the extent of the agreed-upon value of the coins or currency so exchanged. This agreed-upon value constitutes the gross receipts or purchase price subject to tax. Coins or currency becomes articles of tangible personal property having a value greater than face value when they are exchanged for a price greater than face value. However, when a coin or other currency, in the course of circulation, is exchanged at its face value, the sale shall be subject to tax for the face value alone. *Losana Corp. v. Porterfield*, 14 Ohio St.2d 42, 236 N.E.2d 535 (1968).

EXAMPLE 1. Taxpayer operates a furniture store. The taxpayer offers to exchange furniture for silver coins at ten times the face value of any coins dated prior to January 1, 1965. Upon any exchange pursuant to the offer, the value of the coins for purposes of determining the tax on the exchange will be equivalent to the value as agreed upon by the parties without regard to the face value of the coins.

EXAMPLE 2. Taxpayer operates a hardware store. In the regular course of business, the taxpayer receives silver coins dated prior to January 1, 1965. Taxpayer has received the coins at face value for the sales price and only that value is subject to tax.

Also see Attorney General Opinion Griger to Bair, Director of Revenue, May 15, 1980, #80-5-13.

This rule is intended to implement Iowa Code section 422.42(6).

**701—15.19(422,423)** **Trade-ins.**

**15.19(1)** Trade-ins. When tangible personal property is traded toward the purchase price of other tangible personal property, the gross receipts shall be only that portion of the purchase price which is payable in money to the retailer if the following conditions are met:

- a. The tangible personal property is traded to a retailer, and the property traded is the type normally sold in the regular course of the retailer's business; and
- b. The tangible personal property traded to a retailer is intended by the retailer to be ultimately sold at retail; or
- c. The tangible personal property traded to a retailer is intended to be used by the retailer or another in the remanufacturing of a like item.

EXAMPLE 1. A owns a car valued at \$5,000. A trades his used car to XY car dealer for a used car valued at \$12,000. XY car dealer normally sells used cars. Use tax would be due on the \$7,000 in money A paid to XY used car dealer, as both conditions "a" and "b" have been met.

EXAMPLE 2. John Doe has a pickup truck with a value of \$2,000. John wants a boat so he offers to trade his \$2,000 pickup to ABC boat dealer for the purchase of a boat valued at \$5,000. ABC boat dealer is a new and used boat dealer. ABC boat dealer agrees to accept the \$2,000 pickup and \$3,000 cash in trade for the boat. In this example, the tax would be computed on \$5,000. The trade-in provision would not apply because condition “a” has not been met. The property traded is not the type of property normally sold by ABC new and used boat dealer in the regular course of the boat dealer’s business.

EXAMPLE 3. ABC Corporation trades 500 bushels of corn and \$500 cash to the local cooperative elevator for the purchase of various hand tools. The local cooperative elevator normally sells grain in its regular course of business for processing into bread. The trade-in provision in this example would not apply because condition “b” would not be met. The grain traded toward the purchase price of the hand tools when ultimately sold by the cooperative elevator is sold for processing and not at retail.

EXAMPLE 4. Hometown Appliance store is in the business of selling stoves, refrigerators, and other various appliances in Iowa. Hometown Appliance has a refrigerator valued at \$650. Customer A wishes to trade a used refrigerator toward the purchase price of the new refrigerator. Hometown Appliance agrees to accept A’s used refrigerator at a value of \$150 toward the purchase price of the new refrigerator. A pays Hometown Appliance \$500 in money. The trade-in provision applies as both conditions “a” and “b” have been met and tax would be due on the \$500.

Several months later, Hometown Appliance sells the used refrigerator it received from customer A to the local school district which is exempt from sales tax on its purchase. The trade-in provision on the original transaction is still applicable because both conditions “a” and “b” were met. The sale is “at retail,” even if it is a retail sale exempt from tax.

EXAMPLE 5. ABC Auto Supply is in the business of selling various types of automobile and farm implement supplies. The normal selling price for a car generator is \$80. ABC Auto Supply allows a \$20 trade-in credit to any customer who wishes to trade in an unworkable generator. At the time ABC Auto Supply accepts the unusable generator it knows that the generator will not be sold at retail; however, ABC Auto Supply does know that the generator will be sold to XYZ Company which is in the business of rebuilding generators by using existing parts plus new parts. In this example the trade-in provision would apply since conditions “a” and “c” have been met.

**15.19(2)** All the provisions of subrule 15.19(1) apply to the trade-in of vehicles subject to registration when the trade involves retailers of vehicles.

When vehicles subject to registration are traded among persons who are not retailers of vehicles subject to registration, the conditions set forth in 15.19(1) “a” and “b” need not be met. The purchase price is only that portion of the purchase price represented by the difference between the total purchase price of the vehicle subject to registration acquired and the amount of the vehicle subject to registration traded.

This rule applies only when a vehicle is traded for tangible personal property, regardless of whether the transaction is between a retailer and a nonretailer or two nonretailers. The vehicle traded in must be owned by the person(s) trading in the vehicle. It is presumed that the name or names indicated on the title of the vehicle dictate ownership of the vehicle as set forth in Iowa Code section 321.1.

EXAMPLE 1. John Doe has an automobile with a value of \$2,000. John and his neighbor Bill Jones, who has an automobile valued at \$3,500, decide to trade automobiles. John pays Bill \$1,500 cash. Vehicles subject to registration are subject to use tax which is payable to the county treasurer at the time of registration. In this example John would owe use tax on \$1,500 since this is the amount John paid Bill and tax is only due on the cash difference. Bill would not owe any use tax on the vehicle acquired through the trade.

EXAMPLE 2. Joe has a Ford automobile with a value of \$5,000. Joe and his friend Jim, who has a Chevrolet automobile also valued at \$5,000, decide to trade automobiles. Joe and Jim make an even trade, automobile for automobile with no money changing hands. In this example there is no tax due on either automobile because there is no exchange of money.

**15.19(3)** Trade for services. The trade-in provisions found in Iowa Code sections 422.42(5) “b” and 423.1(8) do not apply to taxable enumerated services. When taxable enumerated services are traded, the gross receipts would be determined based on the value of the service or other consideration.

**15.19(4)** Three-way trade-in transactions. In a three-way transaction, the agreement provides that a lessee sell to a third-party dealer a vehicle (or other tangible personal property) which the lessee owns. The lessor then purchases another vehicle from the third-party dealer at a reduced price and leases the vehicle to the lessee. The difference between the reduced sale price and retail price of the vehicle is not allowed as a trade-in on the vehicle for use tax purposes.

EXAMPLE. “A” enters into a three-way agreement with “B,” the lessor. Under the terms of the contract, “A” sells a 2000 Ford Taurus owned by “A” to “C,” a used-car dealer. The retail price for the Ford Taurus is \$30,000. “C” then sells the Ford Taurus to “B” for the reduced price of \$25,000. “B” then leases the Ford Taurus to “A” for a period of 12 months. The \$5,000 difference between the reduced sale price and the retail price of the vehicle is not allowed as a trade-in on the sale of the vehicle for use tax purposes.

This rule is intended to implement Iowa Code sections 422.42(5) “b” and 423.1(8). See also *Reynolds Motor Co. et al v. Iowa Dep’t. of Revenue*, Equity 72050, Dist. Ct. of Scott Cty., Iowa, August 28, 1987.

**701—15.20(422,423) Corporate mergers which do not involve taxable sales of tangible personal property or services.** If title to or possession of tangible personal property or ownership of services is transferred from one corporation to another pursuant to a statutory merger, the transfer is not a “sale” subject to tax if all of the following circumstances exist: (1) the merger is pursuant to statute (for example, Iowa Code section 490.1106); (2) by the terms of that statute, the title or possession of property or services transferred passes from a merging corporation to a surviving corporation and not for any consideration; and (3) the merging corporation is extinguished and dissolved the moment the merger occurs and, as a result of this dissolution, cannot receive any benefit from the merger. Transactions which are not of the type described above may involve taxable sales. See the following court cases relating to this area: *Nachazel v. Mira Co. Mfg.*, 466 N.W.2d 248 (Iowa 1991); *D. Canale & Co. v. Celauro*, 765 S.W.2d 736 (Tenn 1989); and *Commissioner of Revenue v. SCA Disposal Services*, 421 N.E.2d 766 (Mass 1981).

EXAMPLE A: Nonaffiliated Corporations A and C enter into a voluntary merger agreement governed by Iowa Code section 490.1106. A and C are separate and independent, one from the other, and neither is a subsidiary of another corporation. No officer of the one is an officer of the other. A and C voluntarily negotiate an arms-length merger agreement which results in the transfer of A’s assets to C and the dissolution of A. In return, A’s stockholders receive stock in C. A’s transfer of tangible personal property to merged company C is not subject to sales or use tax.

EXAMPLE B: Corporations B, D, and E are independent entities. They enter into a merger agreement governed by Iowa Code section 490.1106 and agree to merge into one surviving corporation which will (after the dissolution of B and D) be E. They agree that the shares of merging corporations will be converted into shares of E on an equal basis. The transfers of property by the corporations which are parties to the merger are not sales subject to Iowa tax.

EXAMPLE C: Corporation F receives all of Corporation G’s outstanding shares from G’s sole stockholder. In return, G’s sole stockholder receives stock from F. Corporation G continues to exist after the transaction as a subsidiary of Corporation F. This particular transaction involves a trade or barter of the stock shares of F and G. There is a barter of the stocks and thus a “sale” as that term is understood for the purposes of Iowa sales tax law. However, because the sale involves only intangible property (the stock shares), that sale is not taxable. The stock exchange transaction would not prevent taxation of subsequent transfers of tangible personal property or services between F and G.

EXAMPLE D: Corporation H buys all the assets of Corporation I which include machinery, equipment, finished goods, and raw materials. Corporation H pays cash for these assets. This transaction does involve the sale of tangible personal property and may be subject to Iowa sales tax. However, see 701—subrule 18.28(2) concerning a casual sale exemption applicable to the liquidation of a business.

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CHAPTER 18  
TAXABLE AND EXEMPT SALES DETERMINED BY METHOD  
OF TRANSACTION OR USAGE  
[Prior to 12/17/86, Revenue Department[730]]

**701—18.1(422,423) Tangible personal property purchased from the United States government.** Tangible personal property purchased from the United States government or any of the governmental agencies shall be exempt from sales tax, but such purchases shall be taxable to the purchaser under the provisions of the use tax law. Persons making purchases from the United States government, unless exempt from the provisions of Iowa Code section 422.44, shall report and pay use tax at the current rate on the purchase price of such purchases.

This rule is intended to implement Iowa Code sections 422.44 and 423.3.

**701—18.2(422,423) Sales of butane, propane and other like gases in cylinder drums, etc.** Sales of butane, propane and other like gases in cylinder drums and other similar containers purchased for cooking, heating and other purposes shall be taxable.

When gas of this type is sold and motor vehicle fuel tax is collected by the seller, tax shall not be due. If Iowa motor vehicle fuel tax is not collected by the seller at the time of the sale, tax shall be collected and remitted to the department, unless the sale is specifically exempt.

If tax is not collected by the seller at the time of sale, any tax due shall be collected by the department at the time the user of the product makes application for a refund of the motor vehicle fuel tax.

The gross receipts from the rental of cylinders, drums and other similar containers by the distributor or dealer of the gas shall be subject to tax when the title remains with the dealer. Gas converter equipment which might be sold to an ultimate consumer shall be subject to tax.

This rule is intended to implement Iowa Code sections 422.42, 422.43, 422.45(11), 423.1 and 423.2.

**701—18.3(422,423) Chemical compounds used to treat water.** Chemical compounds placed in water which is ultimately sold at retail should be purchased exempt from the tax. The chemical compounds become an integral part of property sold at retail. Chemical compounds placed in water which is directly used in processing are exempt from the tax, even if the water is consumed by the processor and not sold at retail.

Chemical compounds which are used to treat water that is not sold at retail or which are not used directly in processing shall be subject to tax. An example would be chlorine or other chemicals used to treat water for a swimming pool.

Special boiler compounds used by processors when live steam is injected into the mash or substance, whereby the steam liquefies and becomes an integral part of the product intended to be sold at retail and does become a part of the finished product, shall be exempt from tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1, and 423.2.

**701—18.4(422) Mortgages and trustees.** Pursuant to the provisions of a chattel mortgage, the receipts from the sale of tangible personal property at a public auction shall be taxable even if the sale is made by virtue of a court decree of foreclosure by an officer appointed by the court for that purpose.

The tax applies to inventory and noninventory goods provided the owner is in the business of making retail sales of tangible personal property or taxable services. In *Re Hubs Repair Shop, Inc.* 28 B.R. 858 (Bkrtcy. 1983).

This rule is intended to implement Iowa Code sections 422.42, 422.43, 423.1 and 423.2.

**701—18.5(422,423) Sales to agencies or instrumentalities of federal, state, county and municipal government.**

**18.5(1)** The gross receipts from the sale of tangible personal property or enumerated taxable services made directly by or to the United States government or to recognized agencies or departments of the United States government shall not be subject to sales tax.

The gross receipts from sales at retail made directly to patients, inmates or employees of an institution or department of the United States government shall be taxable, since they are not made directly to the government. However, sales similarly made by post exchanges and other establishments organized and controlled by federal authority shall not be subject to sales tax.

**18.5(2)** The gross receipts from sales to the United States government, state of Iowa, or federal bureaus, departments, or instrumentalities are not taxable. A sale to government occurs only if a government, pursuant to a contract for sale, takes title or ownership to tangible personal property as a buyer from a seller. No sale to government occurs if a government pays some portion of the cost of sale of an item of tangible personal property but title to and ownership of the property are transferred to another person as a result of the sale. See *AVCO Manufacturing Corporation v. Connelly*, 145 Conn. 161, 140 A.2d 479 (1958) and *Akron Home Medical Services, Inc. v. Lindley*, 25 Ohio St.3d 107, 495 N.E.2d 417 (1986).

EXAMPLE A: Patient A purchases a hospital bed from a drugstore. A percentage of patient A's bill is paid by federal funds from Medicaid. Patient A has purchased a hospital bed, not the federal government, and Iowa tax is due as a result of this sale.

EXAMPLE B: A is a federal government employee. A stays at a hotel while on government business and eats meals there. A pays for the hotel room (treated as the sale of tangible personal property under Iowa sales tax law) and the meals with a credit card. The credit card was issued in A's name, and the cost of the room and meals is billed to A, who pays it. The federal government later reimburses A the entire cost of the room and meals. A has purchased the room and meals, and Iowa sales tax should be charged accordingly.

EXAMPLE C: B is a federal government employee who eats at a restaurant while on government business. B uses a credit card to pay for the meal. The credit card is issued in B's name, but the cost of the meal is billed to the U.S. government which pays that cost. In this situation, the government is the purchaser of the meal on B's behalf, and the sale is exempt from tax.

See rule 701—34.12(423) for an example of the application of this subrule to the motor vehicle use tax.

**18.5(3)** The gross receipts from the sale of goods, wares, merchandise, or services used for public purposes to any tax-certifying or tax-levying body of the state of Iowa or governmental subdivision thereof, including the state board of regents, state department of human services, state department of transportation, and all divisions, boards, commissions, agencies, or instrumentalities of the state, federal, county, or municipal government which have no earnings going to the benefit of an equity investor or stockholder, except the sale of goods, wares, merchandise or services used by or in connection with the operation of any municipally owned public utility engaged in selling gas, electricity, pay television service, or heat to the general public, shall be exempt. The exclusion from exemption for municipally owned pay television service is applicable to sales occurring and services provided on and after July 1, 1991. On and after April 1, 1992, providing sewage service or solid waste collection and disposal service to a county or municipality on behalf of nonresidential commercial operations located within the county or municipality shall be taxable (see rules 701—26.71(422,423) and 26.72(422,423) for more information). Goods, wares, merchandise, or services used for public purposes and sold to any municipally owned solid waste facility which sells all or part of its processed waste as a fuel to a municipally owned public utility shall be exempt.

EXAMPLES:

*a.* A group of exempt instrumentalities, such as cities, issues bonds to finance the construction of a sewage disposal facility. X, a corporation, purchases the bonds but is not involved in the project in any other way. Since X does not enjoy the benefits of earnings of the solid waste facility, the exemption provided the instrumentalities is applicable.

*b.* Corporation Y, which is an instrumentality of the federal government and which Congress has allowed by statute to be subject to state sales and use taxes, purchases tangible personal property. Said purchases are subject to tax because the profits of the corporation are distributed to the stockholders thereof.

c. An instrumentality of government includes an area agency on aging as designated by the Iowa department on aging pursuant to Iowa Code section 231.32.

This tax exemption does not apply to independent contractors who deal with agencies, instrumentalities, or other entities of government. These contractors do not, by virtue of their contracting with governmental entities, acquire any immunity or exemption from taxation for themselves. Sales to these contractors remain subject to tax, even if those sales are of goods or services which a contractor will use in the performance of a contract with a governmental entity. This principle is applicable to construction contractors who create or improve real property for federal, state, county, and municipal instrumentalities or agencies thereof. The contractors shall be subject to sales and use tax on all tangible personal property they purchase regardless of the identity of their construction contract sponsor. See 701—Chapter 19. See also *NLO, Inc. v. Limbach*, 613 N.E.2d 193, 66 Ohio St.3d 389 (1993); *Bill Roberts Inc. v. McNamara*, 539 So.2d 1226 (La. 1989) reh. den. April 27, 1989; *White Oak Corporation v. Department of Revenue Services*, 503 A.2d 582, 198 Conn. 413 (1986).

This rule is intended to implement Iowa Code section 422.45(5).

### **701—18.6(422,423) Relief agencies.**

**18.6(1)** Relief agency means the state, any county, city and county, city or district thereof, or any agency engaged in actual relief work. Nonexclusive examples of relief agencies are Salvation Army, Royal Neighbors, and Masonic Lodge. The sales of tangible personal property or enumerated services to relief agencies are subject to tax. A relief agency may apply to the director for refund of the amount of tax imposed and paid by it, upon the purchase of goods, wares, merchandise, or services rendered, furnished, or performed that are used for free distribution to the poor and needy.

**18.6(2)** Persons are determined to be in the poor and needy category when their incomes and resources are at or below poverty level. The department will use federal poverty guidelines in making this determination.

**18.6(3)** Listed below are some examples where the tax may or may not be refunded to the relief agency:

EXAMPLE: A relief agency purchases clothing for free distribution to a poor and needy person. The tax is refundable.

EXAMPLE: A relief agency pays the gas, light, or telephone bill for a person who is poor and needy. The tax is refundable.

EXAMPLE: An agency purchases items of clothing for residents of their living facility, and is partially reimbursed by the person using the items based upon the recipient's ability to pay. Tax on the portion of cost not recovered by the agency can be claimed as a refund of tax paid by using formula stated in 18.6(6).

**18.6(4)** Demolition v. repair costs. A nonprofit noneducational relief agency is not entitled to a refund of sales tax paid by contractors on building materials used in the alteration, expansion, repair, remodeling or construction of the facility since the materials were sold tax paid to the contractor who is the consumer of the material by statute. See Iowa Code section 422.42(9). However, the relief agency would be entitled to a refund of sales tax paid on the cost of the demolition of the building since the demolition of the building indirectly benefited the poor and needy. 1968 O.A.G. #841.

EXAMPLE: A relief agency, which is not part of a governmental unit, operates a home or orphanage for persons who are poor and needy or for orphan children. Food, lodging, and necessary items are furnished free-of-charge to the residents. The relief agency would be entitled to a refund of any taxes paid to operate this facility; such as, but not limited to, lights, heat, water, telephone, and repair items or services needed to maintain the facility.

**18.6(5)** Claims for refund must be filed quarterly with the department within 45 days after the end of the quarter for which the refund is claimed. Claims are to be submitted on forms provided by the department.

The claim shall include the following information:

- a. The total amount or amounts, valued in money, expended directly or indirectly for goods, wares, merchandise, or services rendered, furnished, or performed used for free distribution to the poor and needy.
- b. List the persons making the sales to the relief agency.
  1. Include the date of the sale.
  2. Include the total amount expended, itemizing sales tax.
  3. Include the date of payment.
  4. Include the check number, receipt number, or paid invoice verifying payment.
- c. List the total operating income received (residents, donations, etc.)
- d. List the operating income received from residents only.
- e. The claim shall be signed by an authorized agent of the relief agency.

**18.6(6)** When a relief agency receives part of its operating income from the poor and needy it is serving, this income will be considered in computing the tax refund paid upon sales to it of products or services used for free distribution to the poor and needy.

To reasonably approximate the correct amount of tax to be refunded, where only a portion of the tax qualifies for refund, a formula will be used by the department. The prescribed formula the department will allow is operating income received from the poor and needy served divided by total operating income received. This percentage will be multiplied by the applicable gross receipts which are considered refundable to arrive at the correct amount of tax to be refunded.

If a person requests an alternative formula, the person shall first list the reasons why an alternative formula is necessary and, secondly, shall outline the proposed formula in detail. If approval is given, the department reserves the right to withdraw the approval or require adjustments in the formula upon notice to the person. Additional refunds or assessments may be made if an audit discloses the formula is incorrect.

This rule is intended to implement Iowa Code sections 422.42(7), 422.43, 422.47, 423.1 and 423.2.

**701—18.7(422,423) Containers, including packing cases, shipping cases, wrapping material and similar items.** The gross receipts from the sale of containers, labels, cartons, pallets, packing cases, wrapping paper, twine, bags, bottles, shipping cases, garment hangers, and other similar articles and receptacles sold to retailers or manufacturers which are purchased for the purpose of packaging or facilitating the transportation of tangible personal property which is sold either at retail or for resale shall be exempt from the tax.

For the purpose of this rule, producers, wholesalers and jobbers are considered retailers or manufacturers.

**18.7(1) Sales to other than retailers or manufacturers.**

a. Containers and all other specified items delivered with tangible personal property which are sold to a final buyer or ultimate consumer shall be exempt from the tax when no separate charge is made for the container. This group includes such items as boxes, cartons, pallets, paper bags, bottles, shipping cases, wrapping paper and twine. If a separate charge is made for the container, the sale of the container is subject to the tax. The sale of wrapping paper, paper bags and like items are subject to the tax when sold at retail.

EXAMPLE: A meat locker purchases materials such as wrapping paper and tape which it uses to wrap meat for customers to whom meat is sold. The wrapping paper and tape would be exempt from tax as being purchased as a packaging material of tangible personal property sold at retail.

EXAMPLE: A meat locker purchases materials such as wrapping paper and tape which it uses to wrap meat for customers who own the meat. The meat locker only performs the service of processing the meat. The wrapping paper and tape are subject to tax as they were not purchased for packaging or for the facilitating of transportation of tangible personal property sold at retail, but were used in the rendering of a service.

b. Packing paper, lining paper, paper used to line boxes and crates, and similar items shall be exempt from the tax if delivered with tangible personal property ultimately sold at retail when no separate charge is made for the paper.

**18.7(2) Labels, tags and nameplates.** Sales of labels, tags, and nameplates attached to products for the benefit of the vendor such as shipping tags, price tags and instructions to cashiers are subject to the tax, unless such items are sold to manufacturers and retailers for packaging or facilitating the transportation of tangible personal property ultimately sold at retail. Labels, tags or nameplates attached to products for the benefit of the final consumer which describe contents, or which relate to the product and are affixed to the product, are exempt from tax.

**18.7(3) Pallets.** Pallets purchased by manufacturers or retailers which are purchased for the purpose of packaging or facilitating the transportation of tangible personal property ultimately sold at retail shall be exempt from the tax.

**18.7(4) Garment hangers.** Garment hangers purchased by manufacturers or retailers and used to facilitate the transportation of tangible personal property or garment hangers delivered with tangible personal property ultimately sold at retail when no separate charge is made are exempt from tax.

Garment hangers used merely to display tangible personal property are taxable.

This rule is intended to implement Iowa Code sections 422.42(3), 422.45(19) and 423.1(1).

#### **701—18.8(422) Auctioneers.**

**18.8(1)** An auctioneer in making a sale, whether of tangible personal property or realty, is by virtue of this employment making the sale as the agent of the principal.

**18.8(2)** Where an auctioneer is conducting a sale and the principal meets the requirement of the casual sale exemption found in Iowa Code section 422.42(12), the gross receipts from the sale are exempt from the tax. See 1970 O.A.G. 774.

**18.8(3)** When an auctioneer is conducting a sale and the principal is in the business of making sales of tangible personal property or taxable services on a recurring basis, the gross receipts from the sale are taxable.

**18.8(4)** Where an auctioneer is selling tangible personal property that the auctioneer owns, the sale of the tangible property owned by the auctioneer is taxable.

This rule is intended to implement Iowa Code section 422.43.

**701—18.9(422) Sales by farmers.** The sale of grain, livestock or any other farm or garden product by the producer thereof ordinarily constitutes a sale for resale, processing or human consumption and shall not be subject to tax.

Farmers selling tangible personal property not otherwise exempt to ultimate consumers or users shall hold a permit and collect and remit sales tax on the gross receipts from their sales.

#### **701—18.10(422,423) Florists.**

**18.10(1)** Florists are engaged in the business of selling tangible personal property at retail and shall be liable for payment of tax measured by the receipts from the sale of flowers, wreaths, bouquets, potted plants and other items of tangible personal property.

**18.10(2)** When florists conduct transactions through a florists' telephonic delivery association, the following rules shall apply when computing tax liability:

*a.* On all orders taken by an Iowa florist and telephoned to a second florist in Iowa for delivery in the state, the sending florist shall be liable for tax, measured at the current rate of tax on gross receipts from the total amount collected from the customer, except the cost of a telegram when a separate charge is made therefor.

*b.* In cases where a florist receives an order pursuant to which the florist gives telephonic instructions to a second florist located outside Iowa for delivery to a point outside Iowa, tax is not owing with respect to any receipts which the florist may realize from the transaction.

*c.* In cases where Iowa florists receive telephonic instructions from other florists located either within or outside of Iowa for the delivery of flowers, the receiving florist will not be held liable for tax with respect to any receipts which the florist may realize from the transaction.

*d.* Rescinded IAB 2/28/96, effective 4/3/96.

**18.10(3)** Florists engaged in selling shrubbery, trees, and similar items. See rule 18.11(422,423). This rule is intended to implement Iowa Code section 422.43.

**701—18.11(422,423) Landscaping materials.** The gross receipts from the sale of sod, dirt, trees, shrubbery, bulbs, sand, rock, woodchips and other similar landscaping materials, when used for landscaping and sold to final consumers, shall be subject to sales tax. For the purpose of this rule, “final consumer” ordinarily means the owner of the land to which the landscaping materials are applied, or a general building contractor when the landscaping contractor contracts with the general building contractor. When a landscaping contractor uses materials to fulfill a contract, the landscape contractor is considered the retailer of the landscaping materials and shall be obligated to collect sales tax on the selling price from the final consumer.

When the retailer of sod, dirt, trees, shrubbery, bulbs, sand, rock, woodchips and other similar landscaping materials installs these items as a part of a contract for landscaping or improving land for a lump sum, the entire gross receipts shall be subject to tax. Any retailer’s charges for “landscaping” shall be taxable. See rule 701—26.62(422) for a description of this service. However, a retailer’s charges for nontaxable services are not taxable if contracted for separately; or, if no written contract exists, the charges are itemized separately on the invoice.

EXAMPLE: A sodding contractor agrees to furnish and install 20 yards of sod for the lump sum of \$20.00 per yard. The sodding contractor must charge the customer \$20.00 sales tax (5% x \$400.00).

EXAMPLE: XYZ Company enters into a contract for the landscaping of an existing office building. XYZ Company agrees to furnish shrubs at \$25.00 each, white rock for \$5.00 per bag and woodchips for \$4.00 per bag. XYZ Company also contracts to install all of the landscaping materials for a fee of \$25.00 per hour. XYZ Company’s hourly fee is taxable if paid for the service of “landscaping” or for some other taxable service, e.g., excavation. If the service is not taxable, the charge is excluded from tax because it was separately contracted for.

The gross receipts from the sale of uncut sod and unexcavated trees, shrubs, and rock shall not be subject to sales or use tax. This is considered a sale of intangible property and not the sale of tangible personal property.

This rule does not apply to the gross receipts from the sale of plants and trees which are eligible for purchase with food coupons under rule 701—20.1(422,423).

This rule is intended to implement Iowa Code sections 422.42, 422.45(12) and 423.1.

**701—18.12(422,423) Hatcheries.** The gross receipts from the sale of egg-type cockerel chicks, broiler chicks and turkey poulters shall be subject to tax. If sale of domestic poultry is for breeding, see rule 701—17.9(422,423).

When pullets and poulters are sold for production purposes, the receipts from the sales shall be exempt from tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

**701—18.13(422,423) Sales by the state of Iowa, its agencies and instrumentalities.** The state of Iowa, its agencies and instrumentalities, are required to collect and remit tax on the gross receipts from taxable retail sales of tangible personal property and taxable services.

This rule does not apply to sales made by cities and counties in the state of Iowa which are specifically exempted from collecting tax by Iowa Code section 422.45(20).

This rule is intended to implement Iowa Code chapters 422 and 423.

**701—18.14(422,423) Sales of livestock and poultry feeds.** Tax shall not apply to the sale of feed for any form of animal life when the product of the animals constitutes food for human consumption. Tax shall apply on feed sold for consumption by pets.

Antibiotics, when administered as an additive to feed or drinking water, and vitamins and minerals sold for livestock and poultry shall be exempt from tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

**701—18.15(422,423) Student fraternities and sororities.** Student fraternities and sororities are not considered to be engaged in the business of selling tangible personal property at retail within the meaning of the sales tax law when they provide their members with meals and lodging for which a flat rate or lump sum is charged. A person engaged in the selling of foods and beverages to such organizations for use in the preparation of meals is making exempt sales at retail and shall not be liable for tax if the food purchases would be exempt under rule 701—20.1(422,423).

Student fraternities or sororities engaged in the business of serving meals to persons other than members for which separate charges are made, or owning and operating canteens through which tangible personal property is sold are deemed to be making taxable sales.

When student fraternities or sororities do not provide their own meals but are provided by caterers, concessionaires or other persons, such caterers, concessionaires or other persons shall be liable for the collection and remittance of tax with respect to their receipts from meals furnished. A similar liability is attached to persons engaged in the business of operating boarding houses, whether for students or other persons.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

**701—18.16(422,423) Photographers and photostaters.** Tax shall apply to the sale of photographs and photostat copies, whether or not produced to the special order of the customer and to charges for the making of photographs or photostat copies out of materials furnished by the customer. A deduction shall not be allowed for the expenses incurred by the photographer, such as rental of equipment or salaries or wages paid to assistants or models, whether or not the expenses are itemized in billings to customers.

Tax shall not apply to the sale of tangible personal property to photographers and photostat producers which becomes an ingredient or component part of photographs or photostat copies sold, such as mounts, frames and sensitized paper; but tax shall apply to the sale of materials to photographers or producers which is used in the processing of photographs or photostat copies.

**18.16(1)** *Sales of photographs to newspaper or magazine publishers for reproduction.* The sale of photographs by a person engaged in the business of making and selling photographs to newspaper or magazine publishers for reproduction shall be taxable.

**18.16(2)** Reserved.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

**701—18.17(422,423) Gravel and stone.** When a contract is entered between a contractor and a governmental body and the contract calls for a stockpile delivery along a road to be improved, it is a sale of tangible personal property to the governmental body. Transactions of this type are exempt from tax. When a contract not only provides for the sale and delivery of materials but also the conversion of the materials into realty improvements, the contractor is the ultimate consumer of the material used and shall be liable for tax. Tax shall apply on the purchase price of the material.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 422.45(5), 423.1 and 423.2.

**701—18.18(422,423) Sale of ice.** The sale of ice for human consumption which may be purchased with food coupons is exempt from tax. The sale of ice used for cooling is subject to tax. See rule 701—20.1(422,423).

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 422.45(12), 423.2 and 423.4.

**701—18.19(422,423) Antiques, curios, old coins or collector's postage stamps.** Curios, antiques, art work, coins, collector's postage stamps and such articles sold to or by art collectors, philatelists, numismatists and other persons who purchase or sell such items of tangible personal property for use and not primarily for resale are sales at retail and shall be subject to tax.

**18.19(1)** Stamps, whether canceled or uncanceled, which are sold by a collector or person engaged in retailing stamps to collectors shall be taxable.

**18.19(2)** The distinction between stamps which are purchased by a collector and stamps which are purchased for their value as evidence of the privilege of the owner to have certain mail carried by the United States government is that which determines whether or not a stamp is taxable or not taxable. A stamp becomes an article of tangible personal property having market value when, because of the demand, it can be sold for a price greater than its face value. On the other hand, when a stamp has only face value, as evidence of the right to certain services or an indication that certain revenue has been paid, it shall not be subject to either sales or use tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

**701—18.20(422,423) Communication services.** This rule applies to sales of communication services billed prior to November 23, 2011. For communication service, telecommunication service, ancillary service and other related communication service billed on or after November 23, 2011, refer to 701—Chapter 224, Iowa Administrative Code. The gross receipts from the sale of all communication services provided in this state are subject to tax. (Communication services are not subject to use tax prior to July 1, 2001. See rule 701—31.7(423).)

**18.20(1) Definitions.**

*a.* Communication service shall mean the act of providing, for a consideration, any medium or method for, or the act of transmission and receipt of, information between two or more points. Each point must be capable of both transmitting and receiving information if “communication” is to occur. The term “communication service” includes, but is not limited to, the transmission and receipt of sound, printed materials (including letters and materials printed by teletype), other images perceived visually and data encoded in computer languages. Any separate charge for the service of transmitting and receiving information between automatic data processing equipment and remote facilities shall be subject to tax, see paragraph 18.34(3)“c.”

*b.* Communication service is provided “in this state” only if both the points of origination and termination of the communication are within the borders of Iowa. Communication service between any other points is “interstate” in nature and not subject to tax.

*c.* “Gross receipts” from the sale of communication service in this state shall mean all charges to any person which are necessary for the ultimate user to secure the service, except those charges which are in the nature of a sale for resale (see subrule 18.20(4)). Such charges shall be taxable if the charges are necessary to secure communication service in this state even though payment of the charge may also be necessary to secure other services. Any charge necessary to secure only interstate communication service shall not be subject to tax if the nature of the service is separately stated and the charge for the service separately billed. For the present, the charges imposed by the Federal Communications Commission and referred to as “access charges for interstate or foreign access services” to an “end user” shall not be subject to tax if separately stated and billed.

Charges imposed or approved by the utilities division of the department of commerce which are necessary to secure long distance service in this state, for example, “end user intrastate access charges,” are taxable. Such charges are taxable whether they result from an expense incurred from operations or are imposed by the mandate of the utilities division and unrelated to any expense actually incurred in providing the service.

If company A collects gross receipts from ultimate users for communication services performed in this state by company B, company A shall treat those gross receipts as its own, collect tax upon them, and remit the tax to the department. The situation is similar to a consignment sale of tangible personal property, and tax must be remitted by the company collecting the gross receipts from the users of the communication services.

As of April 4, 1990, the amount of a surcharge for enhanced 911 emergency telephone service shall not be subject to sales tax if the amount is no more than \$1 per month per telephone access line and the surcharge is separately identified and separately billed. An enhanced 911 emergency telephone service surcharge is one which routes a 911 call to the appropriate public safety answering point and automatically displays a name, address, and telephone number of an incoming 911 call at that answering point.

*d.* Paging services. A one-way paging service is not a taxable enumerated service in Iowa because one-way paging only receives information and is not capable of transmitting information. As a result, this type of pager service is not a two-way transmission.

**18.20(2)** This subrule is applicable to various specific circumstances involving the sale of communication services.

*a.* Companies which bill their subscribers for communication services on a quarterly, semiannual, annual or any other periodic basis shall include the amount of such billings in their gross receipts. The date of the billing shall determine the period for which sales tax shall be remitted. Thus, if the date of a billing is March 31, and the due date for payment of the bill without penalty is April 20, tax upon the gross receipts contained in the bill shall be included in the sales tax return for the first quarter of the year. The same principle shall be used to determine when tax will be included in payment of a sales tax deposit to the department.

*b.* The gross receipts from the service of transmitting messages, night letters, day letters and all other messages of similar nature between two or more points within this state are subject to sales tax.

*c.* Receipts from communication services performed for all divisions, boards, commissions, agencies or instrumentalities of federal, Iowa, county or municipal government, and private, nonprofit educational institutions in this state for educational purposes are exempt from tax, except sales to any tax-levying body used by or in connection with the operation of any municipally owned utility engaged in selling gas, electricity or heat to the general public are subject to tax.

**18.20(3)** This subrule is specifically applicable to companies and other persons providing telephone service in this state. Any reasoning contained in this subrule may also be applied to companies or other persons providing other communication services.

*a.* All companies must have a permit for each business office which provides communication service in this state. The companies must collect and remit tax upon the gross receipts from the operation of such offices.

*b.* If a minimum amount is guaranteed to a company from the operation of any coin-operated telephone, tax shall be computed on the minimum amount guaranteed or the actual taxable gross receipts collected whichever is the greater.

*c.* In computing tax due, the federal taxes identified as such, separately billed and payable by the customer shall be excluded from gross receipts. If the taxes are not separately billed, they shall be subject to Iowa sales tax.

*d.* Telegrams and like charges made to the accounts of subscribers and billed by companies providing telephone service which appear on the subscribers' toll bills are subject to tax.

*e.* Charges for directory assistance service rendered in this state shall be subject to tax. Charges for directory assistance service, separately stated and billed, shall not be subject to tax if the service is interstate in nature.

*f.* The gross receipts from the installation or repair of any inside wire which provides electrical current that allows an electronics device to function shall be subject to tax. Such gross receipts are from the enumerated service of electrical repair or installation, and are thus subject to tax. The gross receipts from "inside wire maintenance charges" for services performed under a service or warranty contract shall also be subject to tax. Depending on circumstances, such receipts are for the enumerated service of "electrical repair" or are incurred under an "optional service or warranty contract" for an enumerated service. In either event, the receipts are subject to tax. See rule 701—18.25(422,423).

*g.* The gross receipts from the rental of any device for home or office use or to provide a communication service to others shall be fully taxable; such receipts are for the enumerated service of "rental of tangible personal property." The gross receipts from rental include rents, royalties, and copyright and license fees. Any periodic fee for maintenance of the device which is included in the gross receipts for the rental of the device shall also be subject to tax.

*h.* The sale of any device, new or used, in place at the time of sale on the customer's premises or sold to the customer elsewhere is the sale of tangible personal property, and thus a sale subject to tax. The sale of an entire inventory of devices may or may not be subject to tax, depending upon whether it does or does not come within the purview of the casual sales exemption, see Iowa Code section 422.42(2)

and subrule 18.28(3). Other exemptions may be applicable as well. See Iowa Code section 422.45 and 701—Chapter 17.

*i.* The gross receipts for the repair or installation of inside wire or the repair or installation of any electronic device, including a telephone or telephone switching equipment shall, as a general rule, be subject to tax whether the customer or purchaser is billed by way of a flat fee or flat hourly charge covering all costs including labor and materials, or by way of a premises visit or trip charge, or by a single charge covering and not distinguishing between charges for labor and materials, or is billed by a charge with labor and material segregated, or is billed for labor only. An exception is this: If the gross receipts are for services on or in connection with new construction, reconstruction, alteration, expansion or remodeling of a building or structure, the gross receipts shall not be subject to tax. For further information concerning the conditions under which such gross receipts for repair or installation would not be subject to tax, see rule 701—19.1(422,423) and 701—subrule 26.2(1).

*j.* If a company bills a handling charge to a customer for sending the customer an electronic device by mail or by a delivery service, this charge shall constitute a part of the gross receipts from the sale of the device and shall be subject to tax. The gross receipts of a mandatory service rendered in connection with the sale of tangible personal property are considered by the department to be a part of the gross receipts from the sale of the property itself and thus subject to tax.

*k.* The purchase or rental of tangible personal property by companies providing communication services shall be subject to tax.

*l.* The amount of any deposit paid by a customer to a company providing communication service if returned to the customer shall not be subject to tax. Any portion of a deposit utilized by a company as payment for the sale of tangible personal property or a taxable service shall be included in gross receipts or gross taxable services and shall be subject to tax.

*m.* On and after July 1, 1997, the gross receipts from sales of prepaid telephone calling cards and prepaid authorization numbers are subject to tax as sales of tangible personal property.

**18.20(4)** When one commercial communication company furnishes another commercial communication company services or facilities which are used by the second company in furnishing communication service to its customers, such services or facilities furnished to the second company are in the nature of a sale for resale; and the charges, including any carrier access charges, shall be exempt from sales tax. The charges for services or facilities initially purchased for resale and subsequently used or consumed by the second company shall be subject to tax, and the tax shall be collected and paid by the seller unless the seller has taken a valid exemption certificate in good faith from the purchaser and other requirements of 701—subrule 15.3(2) are met.

**18.20(5)** Prior to July 1, 1999, charges for access to or use of what is commonly referred to as the “Internet” or charges for other contracted on-line services are the gross receipts from the performance of a taxable service if access is by way of a local or in-state long distance telephone number and if the predominant service offered is two-way transmission and receipt of information from one site to another as described in paragraph “a” of subrule 18.20(1). If a user’s billing address is located in Iowa, a service provider should assume that Internet access or contracted on-line service is provided to that user in Iowa unless the user presents suitable evidence that the site or sites at which these services are furnished are located outside this state.

On and after July 1, 1999, gross receipts from charges paid to a provider for access to an on-line computer service are exempt from tax. An “on-line computer service” is one which provides for or enables multiple users to have computer access to the Internet. Charges paid to a provider for other contracted on-line services which do not provide access to the Internet and which are communication services remain subject to Iowa tax through May 14, 2000.

On and after May 15, 2000, the furnishing of any contracted on-line service is exempt from Iowa tax if the information is made available through a computer server. The exemption applies to all contracted on-line services, as long as they provide access to information through a computer server.

**18.20(6)** The gross receipts paid for the performance of the service of sending or receiving any document commonly referred to as a “fax” from one point to another within this state are subject to sales tax. See 18.20(1)“a.” Gross receipts paid for the service of providing a telephone line or other

transmission path for the use of what is commonly called a “fax” machine are the gross receipts from the performance of a taxable service if the points of transmission and receipt of a fax are in this state. See 18.20(1) “a” and “b.”

EXAMPLE A. Klear Kopy Services is located in Des Moines, Iowa. Klear Kopy charges a customer \$2 to transmit a fax (via its machine) to Dubuque, Iowa. The \$2 is taxable gross receipts. Midwest Telephone Company charges Klear Kopy \$500 per month for the intrastate communications on Klear Kopy’s dedicated fax line. The \$500 is also gross receipts from a taxable communication service.

EXAMPLE B. The XYZ Law Firm is located in Des Moines, Iowa. The firm owns a fax machine and uses the fax machine in the performance of its legal work to transmit and receive various documents. The firm does not perform faxing services but will, on billings for legal services to clients, break out the amount of a billing which is attributable to expenses for faxing. For example, “bill to John Smith for August, 1997, \$1,000 for legal services performed, fax expenses which are part of this billing—\$30.” The \$30 is not gross receipts for the performance of any taxable service, the faxing service performed being only incidental to the performance of the nontaxable legal services.

EXAMPLE C. The TUV Hospital is located in Cedar Rapids, Iowa. The surgeons successfully perform delicate brain surgery on patient W. To perform that surgery it was necessary for the surgeons to consult with a number of colleagues; the consultation was via E-mail. After the operation, the TUV Hospital sent patient W a bill for \$10,000 of nontaxable hospital services. Listed as an expense is “E-mail—\$200.” The E-mail services are performed incidentally to the nontaxable hospital services; therefore, the \$200 is not taxable gross receipts.

EXAMPLE D. D is a dentist practicing in Mason City, Iowa. D subscribes to an on-line service which, in return for a monthly fee, informs its subscribers of the latest dental surgery techniques and advises them about how these techniques can be applied to individual patients. After consultation on patient E’s problem through the on-line service, D performs complex surgery on patient E. D’s bill to patient E reads as follows: “dental reconstruction—\$2,750; on-line consultation portion—\$240.” The \$240 is not taxable gross receipts, this charge being incidental to the nontaxable charge for dental work.

**18.20(7)** *Communication service, telecommunications service, ancillary service, and other similar communication service.*

*a. Purpose.* This subrule covers various provisions related to communication service, telecommunications service, ancillary service, and other similar communication service.

*b. Definitions.*

(1) “*Air-to-ground radio telephone service*” means a radio service in which common carriers are authorized to offer and provide radio telecommunications service for hire to subscribers in aircraft.

(2) “*Ancillary services*” means services that are associated with or incidental to the provision of a telecommunications service. The term includes, but is not limited to, detailed communications billing service, directory assistance, vertical service, and voice mail services.

(3) “*Call-by-call basis*” means any method of charging for telecommunications services where the price is measured by individual calls.

(4) “*Communications channel*” means a physical or virtual path of communications over which signals are transmitted between or among customer channel termination points.

(5) “*Communication service*” means the act of communicating using any system or the act of transmission and receipt of information between two or more points. Each point must be capable of both transmitting and receiving information if communication is to occur. The term “communication service” includes, but is not limited to, the transmission and receipt of sound, printed materials (including letters and other materials), other images perceived visually and data encoded in computer languages. Communication service also includes telecommunications service, ancillary service and other similar communication service.

(6) “*Conference bridging service*” means an ancillary service that links two or more participants of an audio or video conference call and may include the provision of a telephone number. Conference bridging service does not include telecommunications services used to reach the conference bridge.

(7) “*Customer*” means the person or entity that contracts with the seller of telecommunications services. If the end user of telecommunications services is not the contracting party, the end user of the

telecommunications service is the customer of the telecommunications service. For purposes of sourcing sales of telecommunications services, the end user of the telecommunications service is the customer of the telecommunications service when the end user is not also the contracting party. "Customer" does not include a reseller of telecommunications service or for mobile telecommunications service of a serving carrier under an agreement to serve the customer outside the home service provider's licensed service area.

(8) "*Customer channel termination point*" means the location where the customer either inputs or receives the communications.

(9) "*Detailed telecommunications billing service*" means an ancillary service of separately stating information pertaining to individual calls on a customer's billing statement.

(10) "*Directory assistance*" means an ancillary service of providing telephone number information and address information.

(11) "*End user*" means the person who utilizes the telecommunication service. In the case of an entity, "end user" means the individual who utilizes the service on behalf of the entity.

(12) "*Fixed wireless service*" means a telecommunications service that provides radio communication between fixed points.

(13) "*Home service provider*" means the same as defined in Section 124(5) of Public Law 106-252, 4 U.S.C. § 124(5) (Mobile Telecommunications Sourcing Act). The home service provider is the facilities-based carrier or reseller with which the customer contracts for the provision of mobile telecommunications services.

(14) "*Interstate*" means a telecommunications service that originates in one United States state or a United States territory or possession and terminates in a different United States state or a United States territory or possession.

(15) "*Intrastate*" means a telecommunications service that originates in one United States state or a United States territory or possession and terminates in the same United States state or a United States territory or possession.

(16) "*Mobile telecommunications service*" means commercial mobile radio service; that is, a radio communication service carried on between mobile stations or receivers and land stations and by mobile stations communicating among themselves.

(17) "*Mobile wireless service*" means a telecommunications service that is transmitted, conveyed, or routed regardless of the technology used, whereby the origination and/or termination points of the transmission, conveyance, or routing are not fixed, including, by example only, telecommunications services that are provided by a commercial mobile radio service provider.

(18) "*Paging service*" means a telecommunications service that provides transmission of coded radio signals for the purpose of activating specific pagers. This transmission may include messages and sounds.

(19) "*Pay telephone service*" means a telecommunications service provided through any pay telephone. Pay telephone service also includes coin operated telephone service paid for by inserting money into a telephone accepting direct deposits of money to operate.

(20) "*Place of primary use*" means the street address representative of where the customer's use of the telecommunications service primarily occurs, which must be the residential street address or the primary business street address of the customer. In the case of mobile telecommunications services, the place of primary use must be within the licensed service area of the home service provider.

(21) "*Postpaid calling service*" means the telecommunications service obtained by making a payment on a call-by-call basis, either through use of a credit card or payment mechanism such as a bank card, travel card, credit card or debit card, or by charge made to a telephone number which is not associated with the origination or termination of the telecommunications service. A postpaid calling service includes a telecommunications service, except a prepaid wireless calling service that would be a prepaid calling service except it is not exclusively a telecommunication service.

(22) "*Prepaid calling service*" means the right to access exclusively telecommunications services, which must be paid for in advance and which enable the origination of calls using an access number or

authorization code, whether manually or electronically dialed, and that are sold in predetermined units or dollars of which the number declines with use in a known amount.

(23) *“Prepaid wireless calling service”* means a telecommunications service that provides the right to utilize mobile wireless service as well as other non-telecommunications services, including the download of digital products delivered electronically, content and ancillary services, which must be paid for in advance that is sold in predetermined units or dollars of which the number declines with use in a known amount.

(24) *“Private communication service”* means a telecommunication service that entitles the customer to exclusive or priority use of a communications channel or group of channels between or among termination points, regardless of the manner in which such channel or channels are connected, and includes switching capacity, extension lines, stations, and any other associated services that are provided in connection with the use of such channel or channels.

(25) *“Residential telecommunications service”* means a telecommunications service or ancillary services provided to an individual for personal use at a residential address, including an individual dwelling unit, such as an apartment. In the case of institutions where individuals reside, such as schools or nursing homes, telecommunications service is considered residential if it is provided to and paid for by an individual resident rather than the institution.

(26) *“Service address”* means:

1. The location of the telecommunications equipment to which a customer’s call is charged and from which the call originates or terminates, regardless of where the call is billed or paid.

2. If the location in numbered paragraph “1” of this subparagraph is not known, “service address” means the origination point of the signal of the telecommunications services first identified by either the seller’s telecommunications system or in information received by the seller from its service provider, where the system used to transport such signals is not that of the seller.

3. If the locations in numbered paragraphs “1” and “2” of this subparagraph are not known, the service address means the location of the customer’s place of primary use.

(27) *“Telecommunications service”* means the electronic transmission, conveyance, or routing of voice, data, audio, video, or any other information or signals to a point, or between or among points. The term includes any transmission, conveyance, or routing in which computer processing applications are used to act on the form, code, or protocol of the content for purposes of transmission, conveyance, or routing without regard to whether such service is referred to as voice-over Internet protocol services or is classified by the Federal Communications Commission as enhanced or value-added. “Telecommunications service” does not include the following:

1. Data processing and information services that allow data to be generated, acquired, stored, processed, or retrieved and delivered by an electronic transmission to a purchaser where the purchaser’s primary purpose for the underlying transaction is the processed data or information;

2. Installation or maintenance of wiring or equipment on a customer’s premises;

3. Tangible personal property;

4. Advertising, including but not limited to directory advertising;

5. Billing and collection services provided to third parties;

6. Internet access service;

7. Radio and television audio and video programming services, regardless of the medium, including the furnishing of transmission, conveyance, or routing of the service by the programming service provider. Radio and television audio and video programming services shall include, but not be limited to, cable service and audio and video programming services delivered by a commercial mobile radio service provider;

8. Ancillary service;

9. Digital products delivered electronically, including but not limited to software, music, video, reading materials or ring tones.

(28) *“Value-added non-voice data service”* means a service that otherwise meets the definition of telecommunications services in which computer processing applications are used to act on the form,

content, code, or protocol of the information or data primarily for a purpose other than transmission, conveyance, or routing.

(29) “*Vertical service*” means an ancillary service that is offered in connection with one or more telecommunications services, which offers advanced calling features that allow customers to identify callers and to manage multiple calls and call connections. Nonexclusive examples of vertical service include call forwarding, caller ID, three-way calling, and conference bridging services.

(30) “*Voice mail service*” means an ancillary service that enables the customer to store, send, or receive recorded messages. Voice mail service does not include any vertical services that the customer may be required to have in order to utilize the voice mail service.

*c. Taxable communication service, telecommunications service, ancillary service, and other similar communication service.* The sales price from the sale of communication service, telecommunications service, ancillary service, and other similar communication service is subject to the sales or use tax. The following is a nonexclusive list of services subject to the Iowa sales and use tax:

- (1) Air-to-ground radio telephone service;
- (2) Ancillary services except detailed communications billing service;
- (3) Conference bridging service;
- (4) Fixed wireless service;
- (5) Mobile wireless service;
- (6) Pay telephone service;
- (7) Postpaid calling service;
- (8) Prepaid calling service;
- (9) Prepaid wireless calling service;
- (10) Private communication service;
- (11) Residential telecommunications service.

*d. Nontaxable communication service, telecommunications service, ancillary service, and other similar communication service.* The following services are not subject to the Iowa sales and use tax:

- (1) Detailed communications billing service;
- (2) Internet access fees or charges;
- (3) One-way paging services that only receive information and are not capable of transmitting information;
- (4) Value-added non-voice data service;
- (5) Any charge necessary to secure only interstate communication service if the nature of the service is separately stated and the charge for the interstate service is separately billed.

*e. Sourcing of telecommunications services.*

(1) General sourcing principles apply to telecommunications services unless the service falls under one of the exceptions set out in paragraph “e.”

(2) Exceptions. The following telecommunications services and products are sourced in accordance with the principles set out in subparagraph (2):

1. Mobile telecommunications service is sourced to the place of primary use, unless the service is prepaid wireless calling service.

2. Prepaid calling service is sourced as provided under Iowa Code section 423.15. However, if the seller has sufficient information available, the sale of prepaid wireless calling service may be sourced to the location of the place of primary use.

3. A sale of a private telecommunications service is sourced as follows:

- Service for a separate charge related to a customer channel termination point is sourced to each level of jurisdiction in which the customer channel termination point is located.

- Service where all customer termination points are located entirely within one jurisdiction or levels of jurisdiction is sourced in the jurisdiction in which the customer channel termination points are located.

- Service for segments of a channel between two customer channel termination points located in different jurisdictions and which segments of channel are separately charged is sourced 50 percent in each level of jurisdiction in which the customer channel termination points are located.

- Service for segments of a channel located in more than one jurisdiction or levels of jurisdiction and which segments are not separately billed is sourced in each jurisdiction based on the percentage determined by dividing the number of customer channel termination points in the jurisdiction by the total number of customer channel termination points.

4. The sale of Internet access service is sourced to the customer's place of primary use.

5. The sale of an ancillary service is sourced to the customer's place of primary use.

6. A postpaid calling service is sourced to the origination point of the telecommunications signal as first identified by either (a) the seller's telecommunications system or (b) information received by the seller from its service provider, where the system used to transport the signals is not that of the seller.

7. The sale of telecommunications service sold on a call-by-call basis is sourced to (a) each level of taxing jurisdiction where the call originates and terminates in that jurisdiction or (b) each level of taxing jurisdiction where the call either originates or terminates and in which the service address is also located.

8. The sale of telecommunications services sold on a basis other than a call-by-call basis is sourced to the customer's place of primary use.

9. The sale of the following telecommunication services is sourced to each level of taxing jurisdiction as follows:

- A sale of mobile telecommunications services, other than prepaid calling service, is sourced to the customer's place of primary use as required by the federal Mobile Telecommunications Sourcing Act.

- A sale of postpaid calling service is sourced to the origination point of the telecommunications signal as first identified by either (a) the seller's telecommunications system or (b) information received by the seller from its service provider, where the system used to transport such signals is not that of the seller.

*f. Bundled transaction.*

- (1) A "bundled transaction" is the retail sale of two or more products where (a) the products are otherwise distinct and identifiable, and (b) the products are sold for one non-itemized price. A bundled transaction does not include the sale of any products in which the sales price varies or is negotiable based on the selection by the purchaser of the products included in the transaction.

- (2) In the case of a bundled transaction that includes any of the following: telecommunications service, ancillary service, Internet access, or audio or video programming service:

1. If the price is attributable to products that are taxable and products that are nontaxable, the portion of the price attributable to the nontaxable products will be subject to tax unless the provider can identify by reasonable and verifiable standards such portion from its books and records that are kept in the regular course of business for other purposes, including, but not limited to, non-tax purposes.

2. If the price is attributable to products that are subject to tax at different tax rates, the total price may be treated as attributable to the products subject to tax at the highest tax rate unless the provider can identify by reasonable and verifiable standards the portion of the price attributable to the products subject to tax at the lower rate from its books and records that are kept in the regular course of business for other purposes, including but not limited to non-tax purposes.

3. The provisions of this subrule shall apply unless otherwise provided by federal law.

*g. Direct pay permit.* The department may issue a direct pay permit that allows the holder to purchase tangible personal property or taxable services without payment of the tax to the seller. The direct pay permit holder cannot use the direct pay permit for the purchase of communication service, telecommunications service, ancillary services, or other similar communication service. The seller should charge and collect the sales or use tax from the purchaser on the taxable sales of communication service, telecommunications service, ancillary services, and other similar communication service.

*h. Credit.* A taxpayer subject to sales or use tax on communication service, telecommunications service, ancillary service or other similar communication service who has paid any legally imposed sales or use tax on such service to another jurisdiction outside the state of Iowa is allowed a credit against the sales or use tax imposed by the state of Iowa equal to the sales or use tax paid to the other taxing jurisdictions.

*i. Sales of communication service, telecommunications service, ancillary service, or other similar communication service to the United States government or the state government of Iowa.* Sales of communication service, telecommunications services, ancillary services, or other similar communication service to the United States government or its agencies or to the state of Iowa or its agencies are not subject to sales or use tax. In order to be a sale to the United States government or to the state government of Iowa, the government or agency involved must make the purchase of the services and pay directly to the vendor the purchase price of the services. Telecommunications service providers should obtain an exemption certificate from each agency for their records.

*j. Retailers liable for collecting and remitting tax.* Retailers that sell taxable communication service, telecommunications service, ancillary services, or other similar communication service are liable for collecting and remitting the state sales or use tax and any applicable local sales tax on the amounts of the sales.

This rule is intended to implement Iowa Code sections 34A.7(1)“c”(2), 422.42(2), 422.42(3), 422.43(9), 422.45(5), 422.45(8), 422.45 and 422.51(1) and Iowa Code Supplement section 422.45 as amended by 2000 Iowa Acts, chapter 1189, section 29.

[ARC 8021B, IAB 7/29/09, effective 9/2/09; ARC 9814B, IAB 10/19/11, effective 11/23/11]

**701—18.21(422,423) Morticians or funeral directors.** A mortician or funeral director is engaged in the business of selling both tangible personal property and funeral services. Examples of the former are caskets, other burial containers, flowers, and grave clothing. Examples of the latter are cremation, transportation by hearse and embalming. Tax is due only upon gross receipts from the sale of tangible personal property and taxable services, and not upon gross receipts from the sale of nontaxable services.

If a mortician or funeral director separately itemizes charges for tangible personal property, taxable services and nontaxable services, as required by the rules of the Federal Trade Commission, or Iowa Code section 523A.8(1)“b,” whichever is applicable, tax is due only upon the gross receipts from the sales of tangible personal property and taxable services. If contrary to the rules or the statute, or if the applicable rules are rescinded or the statute repealed, and the mortician or funeral director charges a lump sum to a customer covering the entire cost of the funeral without dividing the charges for sales of tangible personal property and taxable and nontaxable services, the mortician or funeral director shall report the full amount of the funeral bill less any cash advanced by the mortician or funeral director, with tax due on 50 percent of the difference. *Kistner v. Iowa State Board of Assessment and Review*, 224 Iowa 404, 280 N.W. 587 (1938). Cash advance items may include, but are not limited to, the following: cemetery or crematory services, pallbearers, public transportation, clergy honoraria, flowers, musicians, singers, nurses, obituary notices, gratuities, and death certificates.

The mortician or funeral director is considered to be purchasing caskets, outer burial containers, and grave clothing for resale, and may purchase these items from suppliers without payment of tax. The mortician or director should present the supplier with a certificate of resale as set out in rule 701—15.3(422,423). A mortician or director is considered to be the user or consumer of office furniture and equipment, funeral home furnishings, advertising calendars, booklets, motor vehicles and accessories, embalming equipment, instruments, fluid and other chemicals used in embalming, cosmetics, and grave equipment, stretchers, baskets, and other items if title or possession does not pass to the customer. *Kistner*; *supra*.

For purposes of this rule, the terms of morticians or funeral directors shall also include cemeteries, cemetery associations and anyone engaged in activities similar to those discussed in the rule.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

**701—18.22(422,423) Physicians, dentists, surgeons, ophthalmologists, oculists, optometrists, and opticians.** Physicians, dentists, surgeons, ophthalmologists, oculists, optometrists, and opticians shall not be liable for tax on services rendered such as examinations, consultations, diagnosis, surgery and other kindred services, nor on the applicable exemptions prescribed under 701—Chapter 20.

The purchase of materials, supplies, and equipment by these persons is subject to tax unless the particular item is exempt from tax when purchased by an individual for the individual’s own use. For

example, the purchase for use in the office of prescription drugs would not be subject to tax nor would the purchase of prosthetic devices such as artificial limbs or eyes.

Sales of tangible personal property to dentists, which are to be affixed to the person of a patient as an ingredient or component part of a dental prosthetic device, are exempt from tax. These include artificial teeth, and facings, dental crowns, dental mercury and acrylic, porcelain, gold, silver, alloy, and synthetic filling materials.

Sales of tangible personal property to physicians or surgeons, which are prescription drugs to be used or consumed by a patient, are exempt from tax.

Sales of tangible personal property to ophthalmologists, oculists, optometrists, and opticians, which are prosthetic devices designed, manufactured, or adjusted to fit a patient, are exempt from tax. These include prescription eyeglasses, contact lenses, frames, and lenses.

The purchase by such persons of materials such as pumice, tongue depressors, stethoscopes, which are not in themselves exempt from tax, would be subject to tax when purchased by such professions.

The purchase of equipment, such as an X-ray machine, X-ray photograph or frames for use by such persons is subject to tax. On the other hand, the purchase of an item of equipment that is utilized directly in the care of an illness, injury or disease, which item would be exempt if purchased directly by the patient, is not subject to tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 422.45(13-15), 423.2 and 423.4(4).

**701—18.23(422) Veterinarians.** Purchase of food, drugs, medicines, bandages, dressings, serums, tonics, and the like, but not to include tools and equipment, which are used in treating livestock raised as part of agricultural production is exempt from tax. Where these same items are used in treating animals maintained as pets for hobby purposes, sales tax is due. See rule 701—18.48(422,423) for an exemption for machinery used in livestock or dairy production which may be applicable to veterinarians but should be claimed only with caution by them.

A veterinarian engaged in retail sales, in addition to furnishing professional services, must account for sales tax on the gross receipts from such sales.

This rule is intended to implement Iowa Code sections 422.42(3) and 422.43.

**701—18.24(422,423) Hospitals, infirmaries and sanitariums.** Hospitals, infirmaries, sanitariums, and like institutions are engaged primarily in rendering services. These facilities shall not be subject to tax on their purchases of items of tangible personal property exempt under 701—Chapter 20 when the items would be exempt if purchased by the individual and if the item is used substantially for the tax-exempt purpose. See rule 18.59(422,423) for an exemption applicable to sales of goods and furnishing of services on and after July 1, 1998, to a nonprofit hospital.

Hospitals, infirmaries, and sanitariums may be the purchasers for use or consumption of tangible personal property used or consumed in furnishing services. *Modern Dairy Co. v. Department of Revenue*, 413 Ill. 55, 108 N.E.2d 8 (1952). However, tangible personal property can be purchased for resale by these facilities and, if purchased for resale, is exempt from tax on the purchases. *Burrows Co. v. Hollingsworth*, 415 Ill. 202, 112 N.E.2d 706 (1953); *Fefferman v. Marohn*, 408 Ill. 542, 97 N.E.2d 785 (1951). Property is purchased for resale if the conditions in subrule 18.31(1) are applicable. See also 701—subrule 15.3(2) with respect to resale exemption certificates.

Depending upon the circumstances, a nonprofit facility may be a charitable institution or organization; a profit facility is not. *Northwest Community Hospital v. Board of Review of City of Des Moines*, 229 N.W.2d 738 (Iowa 1975); *Readlyn Hospital v. Hoth*, 223 Iowa 341, 272 N.W. 90 (1937). Sales by these nonprofit facilities would be exempt from tax if the requirements of Iowa Code section 422.45(3) are met. See rule 701—17.1(422,423).

This rule is intended to implement Iowa Code section 422.45 as amended by 1998 Iowa Acts, House File 2513, and chapter 423.

**701—18.25(422,423) Warranties and maintenance contracts.**

**18.25(1)** In general—definitions. “Mandatory warranty.” A warranty is mandatory within the meaning of this regulation when the buyer, as a condition of the sale, is required to purchase the warranty or guaranty contract from the seller. “Optional warranty.” A warranty is optional within the meaning of this regulation when the buyer is not required to purchase the warranty or guaranty contract from the seller.

**18.25(2)** Mandatory warranties. When the sale of tangible personal property or services includes the furnishing or replacement of parts or materials which are pursuant to the guaranty provisions of the sales contract, a mandatory warranty exists. If the property subject to the warranty is sold at retail, and the measure of the tax includes any amount charged for the guaranty or warranty, whether or not such amount is purported to be separately stated from the purchase price, the sale of replacement parts and materials to the seller furnishing them thereunder is a sale for resale and not taxable. Labor performed under a mandatory warranty which is in connection with an enumerated taxable service is also exempt from tax.

**18.25(3)** Optional warranties. For periods after June 30, 1981.

*a.* The sale of optional service or warranty contracts which provide for the furnishing of labor and materials and require the furnishing of any taxable service enumerated under Iowa Code section 422.43 is considered a sale of tangible personal property the gross receipts from which are subject to tax at the time of sale except as described below.

*b.* On and after July 1, 1995, the sale of a residential service contract regulated under Iowa Code chapter 523C is not considered to be the sale of tangible personal property, and gross receipts from the sales of these service contracts are no longer subject to tax, and the gross receipts from taxable services performed for the providers of residential service contracts are now subject to tax. See the examples below for more detailed explanation. A “residential service contract” is defined in Iowa Code subsection 523C.1(8) to be: a contract or agreement between a residential customer and a service company which undertakes, for a predetermined fee and for a specified period of time, to maintain, repair, or replace all or any part of the structural components, appliances, or electrical, plumbing, heating, cooling, or air-conditioning systems of residential property containing not more than four dwelling units.

EXAMPLE A. John Jones purchases a residential service contract for \$3,000 on July 1, 1994. He pays \$150 of Iowa state sales tax. On December 1, 1994, his furnace malfunctions. The service company which sold Mr. Jones the contract pays Smith Furnace Repair \$700 to fix the furnace. No sales tax is due on the \$700 charge.

EXAMPLE B. Bob Jones purchases a residential service contract for \$3,000 on July 1, 1995. No sales tax is owing or paid. On December 1, 1995, his furnace becomes inoperable. The service company which sold Mr. Jones the contract pays Smith Furnace Repair \$900 to fix Mr. Jones’ furnace. Sales tax of \$45 is due based on the \$900.

*c.* On and after July 1, 1998, if an optional service or warranty contract is a computer software maintenance or support service contract and the contract provides for the furnishing of technical support services only and not for the furnishing of any materials, then no tax is imposed on the furnishing of those services under this subrule. If a computer software maintenance or support service contract provides for the performance of nontaxable services and the taxable transfer of tangible personal property, and no separate fee is stated for either the performance of the service or the transfer of the property, then state sales tax of 5 percent shall be imposed on 50 percent of the gross receipts from the sale of the contract. If a charge for the performance of the nontaxable service is separately stated, see subrule 18.25(5) below.

**18.25(4)** A preventive maintenance contract is a contract which requires only the visual inspection of equipment and no repair is or shall be included. The gross receipts from the sale of a preventive maintenance contract is not subject to tax.

**18.25(5)** Additional charges for parts and labor furnished in addition to that covered by a warranty or maintenance contract which are for enumerated taxable services shall be subject to tax. Only parts and

not labor will be subject to tax where a nontaxable service is performed if the labor charge is separately stated.

This rule is intended to implement Iowa Code sections 422.42 and 423.2 and Iowa Code Supplement section 422.43 as amended by 1998 Iowa Acts, Senate File 2288.

**701—18.26(422) Service charge and gratuity.** When the purchase of any food, beverage or meals automatically and invariably results in the inclusion of a mandatory service charge to the total price for such food, beverage or meal, the amounts so included shall be subject to tax. The term “service charge” means either a fixed percentage of the total price of or a charge for food, beverage or meal.

The mandatory service charge shall be considered: (1) a required part of a transaction arising from a taxable sale and a contractual obligation of a purchaser to pay to a vendor arising directly from and as a condition of the making of the sale and (2) a fixed labor cost included in the price for food, beverage or meal even though such charge is separately stated from the charge for the food, beverage or meal.

When a gratuity is voluntarily given for food, beverage or meal it shall be considered a tip and not subject to tax.

*Cohen v. Playboy Club International, Inc.*, 19 Ill. App. 3d 215, 311 N.E.2d 336; *Baltimore Country Club, Inc. v. Comptroller of Treasury*, 272 Md. 65, 321 A.2d 308.

This rule is intended to implement Iowa Code section 422.43.

**701—18.27(422) Advertising agencies, commercial artists, and designers.**

**18.27(1) Nontaxable services.** Tax does not apply to charges by advertising agencies, commercial artists, or designers for services rendered that do not represent services that are a part of a sale of tangible personal property, or a labor or service cost in the production of tangible personal property. Examples of such nontaxable services are: writing original manuscripts and news releases; writing copy for use in newspapers, magazines, or other advertising, or to be broadcast on television or radio, compiling statistical and other information; placing or arranging for the placing of advertising in media, such as newspapers, magazines, or other publications; billboards and other facilities used in public transportation; and delivering or causing the delivery of brochures, pamphlets, cards, and similar items. Charges for such items as supervision, consultation, research, postage, express, transportation and travel expense, if involved in the rendering of such services, are likewise not taxable.

**18.27(2) Agency fee or commission.** When an amount billed as an agency “fee,” “service charge,” or “commission” represents a charge or part of the charge for any of the nontaxable services described under 18.27(1), the amount so billed is not taxable. Such charge by an advertising agency will be considered to be made for nontaxable services.

**18.27(3) Items taxable.** The tax applies to the entire amount charged to clients for items of tangible personal property such as drawings, paintings, designs, photographs, lettering, assemblies and printed matter. This includes the cost of typography and reproduction proofs when the latter is used as part of a paste-up, “mechanical” or assembly. Whether the items of property are used for reproduction or display purposes is immaterial.

**18.27(4) Preliminary art.** “Preliminary art” as used herein means roughs, visualizations, comprehensives and layouts prepared for acceptance by clients before a contract is entered into or approval is given for finished art. (“Finished art” as used herein means the final art used for actual reproduction by photo-mechanical or other processes.) Tax does not apply to separate charges for preliminary art, except where the preliminary art becomes physically incorporated into the finished art as for example, when the finished art is made by inking directly over a pencil sketch or drawing, or the approved layout is used as camera copy for reproduction.

The charge for preliminary art must be billed separately to the client, either on a separate billing or separately charged for on the billing for the finished art. It must be clearly identified on the billing as preliminary art, of one or more of the types mentioned in the preceding paragraph. Proof of ordering or producing the preliminary art prior to date of contract or approval for finished art shall be evidenced by purchase orders of the buyer, or by work orders or other records of the seller.

The following situations are examples of when the sale of “finished art” is taxable:

*a.* Finished art which is sold to customers to be used for advertising purposes in newspapers, magazines or the like. After the advertiser contracts with the ad agency for the development of an advertising message or theme, the agency devises ideas (preliminary art) and produces the finished art. The finished art is then delivered to the advertiser or to an agent of the advertiser such as a printer or publisher who is under contract with the advertiser to publish the ad.

*b.* Finished art which is sold to customers, or their agents (e.g., printers), for use in producing printed material. The charge for finished art is taxable even though the art work may later be returned to the ad agency by the purchaser or the printer or used by the customer or the customer's agent to produce a nontaxable item. Since the finished art is not a part of the printed materials, the ad agency's customer is consuming the material and not buying it for resale, or using it in an exempt manner.

*c.* Finished art which is used to produce other tangible personal property sold by the ad agency such as letterhead stationery and business cards. The charge for such art is taxable as part of the selling price for such stationery or business cards. This is true whether or not the agency separately itemizes the charge for such stationery or business cards.

**18.27(5) *Items purchased by agency, artist or designer.*** An advertising agency, artist, or designer is the consumer of tangible personal property used in the operation of its business, such as stationery, ink, paint, tools, drawing tables, T-squares, pens, pencils, and other office supplies. Tax applies to the sale of such property to the agency, artist, or designer. Tax also applies where the agency, artist or designer is the consumer of taxable services.

The agency, artist, or designer is the seller of, and may purchase for resale, any item resold before use, or that becomes physically an ingredient or component part of tangible personal property sold, as, for example, illustration board, paint, ink, rubber cement, flap paper, wrapping paper, photographs, photostats, or art purchased from other artists. Tax also applies where the agency, artist, or designer is the seller at retail of taxable services.

In the event that an agency, artist, or designer is both a consumer and a retailer of such items of tangible personal property as noted in this subsection, such agency, artist or designer should:

*a.* Purchase such items without tax liability if the majority of the items are sold at retail and remit the tax at the time of resale or at the time such items are consumed in the operation of the business.

*b.* Pay tax to suppliers at the time of purchase if the majority of the items will be consumed in the operation of the business and deduct the original cost of any such items subsequently sold at retail when reporting tax on their returns.

**18.27(6) *Construction.*** Nothing contained in this rule shall be construed to provide for an exemption from tax for services expressly taxable in rules 701—26.17(422) and 26.39(422).

**18.27(7) *Advertising agencies, commercial artists and designers as agent of client or as a nonagent.***

*a.* In general. A true agent relationship depends upon the facts with respect to each transaction. An agent is one who represents another, called the principal, in dealings with third persons. Advertising agencies, commercial artists, and designers may act as agents on behalf of their clients in dealing with third persons or they may act on their own behalf. To the extent advertising agencies, artists and designers act as agents of their clients in acquiring tangible personal property, they are neither purchasers of the property with respect to the supplier nor sellers of the property with respect to their principals.

*b.* When advertising agencies, commercial artists, and designers act as agents of their clients in purchasing property for their clients, the tax applies to the gross receipts from the sale of such property to the advertising agencies, commercial artists, and designers. Unless such advertising agencies, commercial artists and designers act as true agents, they will be regarded as the retailers of tangible personal property furnished to their clients and the tax will apply to the total amount received for such property. Further, nothing in this rule should be construed to be in variance with the opinion of the Iowa Supreme Court in *Rowe vs. Iowa State Tax Commission*, 249 Iowa 1207, 91 N.W.2d 548 (1958).

*c.* To establish that a particular acquisition is made in the capacity of an agent for a client, advertising agencies, commercial artists, and designers (collectively herein referred to as agency) shall act as follows:

1. The agency must clearly disclose to the supplier the name of the client for whom the agency is acting as an agent.

2. The agency must obtain, prior to the acquisition, and retain written evidence of agent status with the client.

3. The price billed to the client, exclusive of any agency fee, must be the same as the amount paid to the supplier. The agency may make no use of the property for its own account, such as commingling the property of a client with another, and the reimbursement for the property should be separately invoiced or shown separately on the invoice to the client.

*d.* Some charges may represent reimbursement for tangible personal property acquired by the agency as agents for its clients and compensation for performing of agency services related thereto. When an advertising agency, commercial artist, or designer establishes that it has acquired tangible personal property as agents for its clients, tax does not apply to the charge made by the agency to its client for reimbursement charges by a supplier or to the charges made for the performance of the agency's services directly related to the acquisition of personal property.

*e.* Advertising agencies, commercial artists, and designers acting as agents shall not issue resale certificates to suppliers.

*f.* Advertising agencies, commercial artists, and designers act as retailers of all items of tangible personal property produced or fabricated by their own employees when they sell to their clients. Advertising agencies, commercial artists, and designers are not agents of their clients with respect to the acquisition of materials incorporated into items of tangible personal property prepared by their employees and sold at retail to their clients.

**18.27(8) Scope.** The scope of this rule is not confined simply to advertising agencies, commercial artists and designers, but also applies to all other businesses whose activities would bring them within the scope of this rule (e.g., printers).

This rule is intended to implement Iowa Code sections 422.43 and 423.2.

#### **701—18.28(422,423) Casual sales.**

**18.28(1)** *Casual sales by persons not retailers or by retailers outside the regular course of business.* Casual sales are exempt from the Iowa sales and use taxes except for the casual sale of vehicles subject to registration, and vehicles subject only to the issuance of a certificate of title. On and after July 1, 1988, the casual sale of aircraft is also taxable. In order for a casual sale to qualify for exemption under this subrule, two conditions must be present: (1) the sale of tangible personal property or taxable services must be of a nonrecurring nature, and (2) the seller, at the time of the sale, must not be engaged for profit in the business of selling tangible goods or services taxed under Iowa Code section 422.43 or, if so engaged, the sale must be outside the regular course of the seller's business (Order of State Board of Tax Review, Martin Development Corporation, Docket No. 136, December 1, 1976, incorporating by reference Order of Department of Revenue Hearing Officer in Docket No. 75-28-6A-A, July 9, 1976). See subrule 18.28(2) for an explanation of the casual sale exemption applicable to the liquidation of a trade or business.

If either of the conditions above are lacking, no casual sale occurs. Moreover, prior to July 1, 1985, the casual sale exemption was limited to sales of tangible personal property, and casual enumerated taxable services did not qualify for the exemption. *KTVO, Inc. v. Bair*, Equity No. 385 Linn County District Court, September 5, 1975.

For the purposes of this subrule, the word "aircraft" refers to any contrivance now known or hereafter invented, which is designed or used for navigation of or flight in the air, for the purpose of transporting persons, property, or both or for crop dusting, aerial surveillance, recreational flying, or for providing some other service. By way of nonexclusive example, balloons, gliders, helicopters, and "ultra lights" are aircraft. Also included within the meaning of the word "aircraft" is any craft registered under Iowa Code section 328.20 or any successor statute thereto.

Sales of capital assets such as equipment, machinery, and furnishings which are not sold as inventory shall be deemed outside the regular course of business (including sales of capital assets during a retailer's liquidation) and the casual sales exemption shall apply as long as such sales are nonrecurring. This will include transactions exempted from state and federal income tax under Section 351 of the Internal Revenue Code.

Two separate selling events outside the regular course of business within a 12-month period shall be considered nonrecurring. Three such separate selling events within a 12-month period shall be considered as recurring. Tax shall only apply commencing with the third separate selling event. However, in the event that a sale event occurs consistently over a span of years, such sale is recurring and not casual, even though only one sales event occurs each year. *Des Moines Police Department v. Bair*, Equity No. CE3-1591, Polk County District Court, November 1, 1976.

EXAMPLE: Corporation A sells the company copy machine at retail to B. At the time of this sale, Corporation A is engaged in the business for profit of selling clothes at retail. Assuming that the sale of the copy machine constitutes a sale of a nonrecurring nature, there is a casual sale because the sale is outside the regular course of Corporation A's business.

EXAMPLE: Corporation C is engaged in the business of lending money secured by collateral. In the course of such business, Corporation C must repossess some collateral and sell it at retail for purposes of payment of loans. Such sales recur from time to time. Notwithstanding that Corporation C is presumably not engaged in the business of selling tangible goods or services for a profit, since the sales are recurring, there is no casual sale. *S & M Finance Co., Fort Dodge v. Iowa State Tax Commission*, 1968, Iowa 162 N.W.2d 505.

EXAMPLE: F, a farmer, does not sell tangible personal property at retail or engage in the performance of any taxable services. F liquidates the farming business and hires a professional auctioneer to auction off many items of tangible personal property. Assuming this liquidation event is casual, all items sold by the auctioneer at retail are casual sales notwithstanding that many different sales to numerous different buyers may occur. See rule 18.8(422).

EXAMPLE: H, an insurance agency, holds a semiannual event to sell its used office furniture. Even though H does not regularly sell tangible personal property at retail, the casual sale exemption does not apply because the selling events are recurring. *Des Moines Police Department v. Bair*, Equity No. CE3-1591, Polk County District Court, November 1, 1976.

EXAMPLE: I, a corporation, has one sales event every year whereby it auctions off capital assets which it has no use for or desires to replace. This event has been a planned function of I and is conducted regularly and consistently over a span of years. Even though this sale event occurs only once a year, it is of a recurring nature because of the pattern of repetitiveness present and, therefore, the casual sale exemption would not apply, regardless of the number of items sold at such sale event each year.

EXAMPLE: J, a corporation engaged in the sale for resale of tangible personal property, sells three capital assets used in J's trade or business consisting of a copy machine, a desk, and a computer. Each sale is made to different buyers and is unrelated to the other sales. The three sales occur in January, June, and October of the same year. The sale made in October consists of a desk. J has not established a pattern of recurring sales of capital assets prior to aforementioned sales of capital assets. Under these circumstances, the sale of the desk is not a casual sale, but the sales of the copy machine and the computer are casual and exempt.

EXAMPLE: K, a corporation, is primarily engaged in the business of road construction. From time to time, it sells used capital assets and scrap materials reclaimed from its road construction work to individuals and businesses. It does not advertise itself as a retailer of these assets and materials but sells them as a matter of courtesy to persons who cannot purchase them elsewhere. After 42 years of operation, it decides to liquidate. Pursuant to that decision, K employs two auctioneers to sell its capital assets and ceases operation after its assets are sold. K had only one capital asset sale during the 12 months immediately preceding each liquidation auction sale. The auction sales are exempt casual sales under this subrule (1) because they are nonrecurring, and (2) because K is not a retailer of the capital assets sold during its liquidation. See *Holland Bros. Construction Co., Inc. v. Iowa State Board of Tax Review*, 611 N.W.2d 495 (Iowa 2000).

EXAMPLE: L, a sole proprietorship, engaged in selling automobile parts at retail, incorporated. The assets of L are sold to the new corporation in exchange for stock and the new corporation now engages in selling automobile parts at retail. The casual sale exemption would apply, but only because of the exemption set out in subrule 18.28(2) infra, since the transfer involves a liquidation of L's business and

the sale of L's inventory to another person (the corporatin) which will continue to engage in a similar trade or business.

The above examples are not the only ones pertaining to the questions of whether a casual sale did or did not occur. However, because of the myriad of factual situations which can and do exist, it is not possible to formulate more detailed rules on this subject matter.

**18.28(2) *Special rules for casual sales involving the liquidation of a trade or business.*** When retailers sell all or substantially all of the tangible personal property held or used in the course of the trade or business for which retailers are required to hold a sales tax permit, the casual sale exemption will apply to exempt those sales only when the following circumstances exist: (1) the trade or business must be transferred to another person, and (2) the transferee must engage in a similar trade or business. The trade or business transferred refers to the place where the business is located since each taxable retail business must have a sales tax permit at each location. For purposes of this casual sale circumstance, it is irrelevant whether the retailer actually has a sales tax permit or not; rather, the relevant circumstance is that the retailer was required to have a sales tax permit. See *Holland Bros. Construction Co., Inc. v. Iowa State Board of Tax Review*, 611 N.W.2d 495 (Iowa 2000). One effect of this is that a retailer who is closing as opposed to transferring a business and is selling inventory in the process of this closing is not entitled to claim the casual sale exemption under this subrule, but see subrule 18.28(1), and the resale exemption is always potentially applicable to sales of inventory. See the examples below for further explanation.

EXAMPLE: L, a hardware store, desires to liquidate the business. L had been selling tangible personal property at retail and was required to have an Iowa retail sales tax permit. L hires a professional auctioneer and all items of inventory, equipment, and fixtures are sold to various purchasers. These items consist of all or substantially all of the tangible personal property held or used by L in the course of the business for which a sales tax permit was required to be held. L, however, does not transfer the trade or business to anyone else. Under these circumstances, the casual sales exemption does not apply to the sale of the inventory, but see subrule 18.28(1) for criteria which determine whether the casual sales exemption applies to the equipment and fixtures.

EXAMPLE: The facts are the same as those in the previous example, except that L is liquidating its business because it attempted to build a new store and its entire inventory was destroyed by fire while in storage. An auctioneer sells L's equipment and trade fixtures to various purchasers. The auctioneer's sale of the equipment and trade fixtures is an exempt casual sale of the type described in subrule 18.28(1) because (1) it is nonrecurring, and (2) it is outside the usual course of L's business. See *Holland Bros. Construction Co., Inc.*, supra.

EXAMPLE: M, a sole proprietorship, incorporated. The assets of M are sold to the new corporation for stock. The new corporation engaged in a similar business. The casual sale exemption would apply.

EXAMPLE: N, an oil company, sells all or substantially all of the tangible personal property of ten company-owned service stations which were held or used in the course of its business, for which N was required to hold a sales tax permit, by bulk sales or otherwise. The sales were made to O, P, and Q and occurred at different times during the same year, each sale being unrelated. N was required to have a sales tax permit for each service station. N transferred its trade or business (each service station) to O, P, and Q, each of whom will engage in the same business N did, i.e., operation of service stations. Even though under these circumstances, the sales by N are recurring, the casual sales exemption would apply since each trade or business was transferred to another person who did engage in a similar trade or business.

EXAMPLE: R, an operator of a restaurant, auctions off to various purchasers who are not engaged in the restaurant business all or substantially all of the tangible personal property held or used in the business for which R was required to hold a retail sales tax permit. R transfers the trade or business to S who then operates a restaurant at the same location R did. Even if S did not purchase any of the tangible personal property, under these circumstances, the casual sales exemption applies. The tangible personal property held or used in the trade or business need not be sold to the same person to whom the trade or business is sold for the exemption to apply.

EXAMPLE: T, a restaurant, sells all of its tangible personal property held or used in the course of its business for which it was required to hold a sales tax permit to U. T also sells its trade or business to U. U engages in the business of operation of a dance hall and does not continue to operate the restaurant. This subrule's casual sales exemption will not apply, but see subrule 18.28(1) for the criteria of a casual sale exemption which could apply.

The above examples are not the only ones pertaining to the questions of whether a casual sale did or did not occur. However, because of the myriad of factual situations which can and do exist, it is not possible to formulate more detailed rules on this subject matter.

**18.28(3) *Casual sales of services.*** Special rule for services rendered, furnished, or performed on or after July 1, 1985. The "casual sale" of an enumerated service has occurred if the following circumstances exist:

a. The service was rendered, furnished, or performed on or after July 1, 1985; and

b. The service was rendered, furnished, or performed on a nonrecurring basis by a seller who, at the time of the sale of the service, is not engaged for profit in the business of selling tangible goods or services taxed under Iowa Code section 422.43, or, if so engaged, the sale was outside the regular course of the seller's business; or

c. The sales of all, or substantially all of the services held or used by a retailer in the course of the retailer's trade or business for which the retailer is required to hold a sales tax permit, if the retailer sells or otherwise transfers the trade or business to another person who engages in a similar trade or business.

EXAMPLE: V ordinarily engages in janitorial and building maintenance or cleaning which are taxable services; see rule 701—26.60(422). Once, as a favor to customer W, V cut customer W's lawn and otherwise performed the taxable service of "lawn care" for customer W. Since this performance of lawn care was not "within V's regular course of business" and was not "recurring," gross receipts from the lawn care are not subject to tax.

EXAMPLE: Corporation X rents a piece of equipment from Y. Y does not otherwise rent equipment and does not engage in the business for profit of selling tangible goods or taxable enumerated services. A casual sale qualifying for the exemption exists.

This rule is intended to implement Iowa Code sections 422.42(12), 422.45(6) and 423.4.

**701—18.29(422,423) Processing, a definition of the word, its beginning and completion characterized with specific examples of processing.**

**18.29(1) *Processing—a definition.*** For the purpose of these rules, "processing" means an operation or a series of operations whereby tangible personal property is subjected to some special treatment by artificial or natural means which changes its form, context, or condition, and results in marketable tangible personal property. These operations are commonly associated with fabricating, compounding, germinating, or manufacturing. *Linwood Stone Products Co. v. State Department of Revenue*, 175 N.W.2d 393 (Iowa 1970).

**18.29(2) *The beginning of processing.*** Processing begins when the "form, context, or condition" of tangible personal property is changed with the intent of eventually transforming the property into a saleable finished product. The severance of raw material from real estate is not processing, even if this severance results in a change in the form, context, or condition of the real estate. *Linwood Stone Products Co. v. State Department of Revenue*, 175 N. W.2d 393 (Iowa 1970). Furthermore, transportation of raw material after it is severed from real estate but prior to the time the initial change in the form, context, or condition of the raw material occurs is not processing. *Southern Sioux County Rural Water System, Inc. v. Iowa Department of Revenue*, 383 N.W.2d 585 (Iowa 1986).

**18.29(3) *The completion of processing.*** Processing ends when the property being processed is in the form in which it is ultimately intended to be sold at retail, *Hy-Vee Food Stores v. Iowa Department of Revenue*, 379 N.W.2d 37 (Iowa App. 1985). The storage or transport of property after that property is transformed into a finished product is not a part of processing.

**18.29(4) *Examples of when processing begins and ends.*** The following examples are intended to clarify but not to contradict the explanation of processing set out in subrules 18.29(2) and 18.29(3).

EXAMPLE A: A company blasts limestone from the ground, bulldozers pick the limestone up and put it in trucks; these trucks transport the limestone to a crusher some distance from the quarry site. The first change in the “form” or “condition” of the limestone, while it is tangible personal property, occurs when the stone is crushed in the crusher. The blasting of the stone from the ground and its transport to the crusher would be acts preparatory to and not a part of processing. Thus, fuel used in the bulldozers and transport trucks would not be fuel used in processing, *Linwood Stone Products*, supra.

EXAMPLE B: Pumps remove water from underground wells and pump that water through pipes to a water treatment plant. At the treatment plant, the water passes initially through an aeration system which adds oxygen to it. At other points in the plant, potassium and chlorine are added to the water and iron is removed. After these acts are performed, clean, drinkable water exists. The first change, however, in the condition of the water occurs when it passes through the aeration system and oxygen is added to it. The withdrawal of the water from the ground and its transport to the aeration system would not be a part of processing. Thus, electricity used by the pumps which pump the water to the aeration system would not be used in processing. However, by way of contrast, electricity used to transport the water between, for example, the aeration system and the point where potassium is added to the water would be used in processing. *Southern Sioux Rural Water System, Inc.*, supra.

EXAMPLE C: Water is processed in a treatment plant. The last act at the plant necessary to render the water drinkable or a “finished product” is the addition of chlorine. After the addition of chlorine, the water is pumped first into wells and later into water towers where it is held for distribution. The pumping of this drinkable water from the point where the chlorine is added to the wells and the tower is not a part of processing because processing of the water ended with the addition of the chlorine; thus, electricity used in these pumps is not electricity used in processing. *Southern Sioux County Rural Water System, Inc.*, supra.

**18.29(5) Integral part of the production of the product test.** Certain activities may be exempt as part of processing if those activities are very closely interconnected with, or an integral part of, the operation of the processing equipment while processing is occurring. *Southern Sioux Rural Water System, Inc.*, supra. Merely because an activity is vital or essential to a processing operation does not make that activity exempt as part of processing unless the activity itself is closely interconnected with, or an integral part of, the operation of the processing equipment while processing is occurring. *Mississippi Valley Milk Producers Ass’n v. Iowa Dept. of Revenue*, 387 N.W.2d 611 (Iowa App. 1986). See the nonexclusive example below.

A manufactures nails. In A’s factory is a machine which draws steel into long rods the width of whatever nail A may wish to manufacture. After this machine draws the steel into the desired-size rods, the rods are moved to a second machine by a conveyor belt. This second machine cuts the rods into the length of nail which A desires. A second conveyor belt then transports these cut rods to a third machine which sharpens one end of the rod to a point and puts a “nail head” on the other end of the rod. The activities of the three machines are clearly processing, in that they are activities which change the form, context or condition of raw material, and as a result of those activities, marketable tangible personal property or a finished product is created. The two conveyor belts move the partially finished nails from one piece of processing equipment to another while processing is occurring. Since the activities of the conveyors are very closely interconnected with and an integral part of the operation of the various pieces of processing equipment while processing is occurring, the conveyor belts are involved in processing as well.

**18.29(6) Other specific examples of processing.** The Iowa Supreme Court has also stated that the following activities are processing: manufacturing ice, refrigerating cheese to age it from “green” to edible, refrigerating eggs to change their flavor, pasteurizing and subsequent refrigeration of milk, “hard” freezing of meat and butter for aging, canning vegetables and cooking foodstuffs; *Fischer Artificial Ice & Cold Storage Co. v. Iowa State Tax Commission*, 248 Iowa 497, 81 N.W.2d 437 (1957); and, *Mississippi Valley Milk Producers v. Iowa Dept. of Revenue and Finance*, 387 N.W.2d 611 (Ia. App. 1986), also crushing of “flat rock” limestone and treating limestone in kilns. *Linwood Stone Products Co. v. State Dept. of Revenue*, 175 N.W.2d 393 (Iowa 1970). See 701—subrule 17.3(2) for an expanded definition of processing with regard to food manufacturing.

**18.29(7) Other department rules concerned with processing.** Various sections of the Iowa Code set out activities that are defined by statute to be “processing.” The rules interpreting these statutes for the purposes of sales and use tax law are the following:

- a. 701—15.3(422,423) Exemption certificates, direct pay permits, fuel used in processing, and beer and wine wholesalers.
- b. 701—17.2(422) Fuel used in processing—when exempt.
- c. 701—17.3(422,423) Processing exemptions.
- d. 701—17.9(422,423) Sales of breeding livestock, fowl, and certain other property used in agricultural production. See 701—subrules 17.9(4), 17.9(5), 17.9(6), and 17.9(7) for processing exemptions.
- e. 701—17.14(422,423) Chemicals, solvents, sorbents, or reagents used in processing.
- f. 701—18.3(422,423) Chemical compounds used to treat water.
- g. 701—18.45(422,423) Sale or rental of computers, industrial machinery and equipment; refund of and exemption from tax paid for periods prior to July 1, 1997.
- h. 701—18.58(422,423) Sales or rentals of machinery, equipment, and computers and sales of fuel and electricity to manufacturers and sales or rentals of computers to commercial enterprises for periods on and after July 1, 1997, but before July 1, 2016.
- i. 701—26.2(422) Enumerated services exempt. See 701—subrule 26.2(2) for the processing exemption.
- j. 701—28.2(423) Processing of property defined.
- k. 701—33.3(423) Fuel consumed in creating power, heat, or steam for processing or generating electric current.
- l. 701—33.7(423) Property used to manufacture certain vehicles to be leased.
- m. For property sold as part of a contract entered into on or after July 1, 2016, computers, machinery, and equipment used for an exempt purpose under Iowa Code section 423.3(47). See rules 701—230.14(423) to 701—230.22(423).  
[ARC 2349C, IAB 1/6/16, effective 2/10/16]

## **701—18.30(422) Taxation of American Indians.**

### **18.30(1) Definitions.**

“*American Indians*” means all persons of Indian descent who are members of any recognized tribe.

“*Settlement*” means all lands within the boundaries of the Mesquakie Indian settlement located in Tama County, Iowa and any other recognized Indian settlement or reservation within the boundaries of the state of Iowa.

**18.30(2) Retail sales tax—tangible personal property.** Retail sales of tangible personal property made on a recognized settlement or reservation to Indians who are members of the tribe located on that settlement or reservation, where delivery occurs on the reservation, are exempt from tax (*Bryan v. Itasca County*, 426 U.S. 373, 376-77 (1976); *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 475-81 (1976)). Retail sales of tangible personal property made on a recognized settlement or reservation to Indians where delivery occurs off the reservation are subject to tax. Retail sales of tangible personal property made to non-Indians on a recognized settlement or reservation are subject to tax regardless of where the delivery occurs. Sales made to non-Indians are taxable even though the seller may be a member of a recognized settlement or reservation.

**18.30(3) Retail sales tax—services.** Sales of enumerated taxable services and sales made by municipal corporations furnishing gas, electricity, water, heat, or communication services to Indians who are members of the tribe located on the recognized settlement or reservation where delivery of the service occurs are exempt from tax (*Bryan v. Itasca County*, 426 U.S. 373, 376-77 (1976); *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 475-81 (1976)). Sales of enumerated taxable services or sales made by municipal corporations furnishing gas, electricity, water, heat, or communication services to Indians where delivery of the services occurs off a recognized settlement or reservation are subject to tax.

**18.30(4) *Off-reservation purchases.*** Purchases made by Indians off a recognized settlement or reservation are subject to tax if delivery occurs off the reservation. Purchases made by Indians off a recognized settlement or reservation are not subject to tax if delivery is made on the reservation to Indians who are members of the tribe located on that reservation.

See rule 701—33.5(423) for the taxation of tangible personal property and services where the state use tax may be applicable.

This rule is intended to implement Iowa Code sections 422.42, 422.43, and 422.45(1).

**701—18.31(422,423) Tangible personal property purchased by one who is engaged in the performance of a service.**

**18.31(1) *In general. (Effective July 1, 1990)***

*a.* On and after July 1, 1990, tangible personal property purchased by one who is engaged in the performance of a service is purchased for resale and not subject to tax if (1) the provider and user of the service intend that a sale of the property will occur, and (2) the property is transferred to the user of the service in connection with the performance of the service in a form or quantity capable of a fixed or definite price value, and (3) the sale is evidenced by a separate charge for the identifiable piece or quantity of property.

*b.* Prior to July 1, 1990, in those circumstances in which tangible personal property is purchased by one who is engaged in the performance of a service and the property is transferred to the customer in conjunction with a performance of the service in a form or quantity which is capable of any fixed or definite price value, but the actual sale of the property is not indicated by a separate charge for the identifiable item, the burden of proving that the property was purchased for resale by one engaged in the performance of a service and not subject to tax at the time of purchase is upon the person engaged in the performance of a service who asserts this.

*c.* Tangible personal property which is not sold in the manner set forth in “*a*” or “*b*” above is not purchased for resale and thus is subject to tax at the time of purchase by one engaged in the performance of a service. Such tangible personal property is considered to be consumed by the purchaser who is engaged in the performance of a service and the person performing the service shall pay tax upon the sale at the time of purchase.

**EXAMPLE:** An investment counselor purchases envelopes. These envelopes are used to send out monthly reports to the investment counselor’s clients regarding their accounts. Tax is due at the time the investment counselor purchases the envelopes if the clients are not billed for these items. Each envelope is transferred to a client in a form or quantity which is capable of a fixed or definite price value. However, there must also be an actual sale to the client (customer) of an item of personal property in order that there be a “resale” of the item.

An automobile repair shop purchases solvents which are used in cleaning automobile parts and thus in performing its automobile repair service. Tax is due at the time the automobile repair shop purchases the solvent since the solvents are not sold to the customer and, in this case, the item is not transferred to a customer in a form or quantity which is capable of a fixed or definite price value. Thus, the solvent is deemed consumed by the purchaser engaged in the performance of the service.

**EXAMPLE:** A retailer purchases television tubes tax-free where the retailer makes a separate charge for the tube to the customer and since the tube is transferred to the customer in a form or quantity capable of a fixed or definite price value.

**EXAMPLE:** A beauty or barber shop purchases shampoo and other items to be used in the performance of its service. Tax is due at the time the beauty or barber shop purchases such items from its supplier, where the customers of the beauty or barber shop are not separately billed for the item, and because it is not transferred to the customer in a form or quantity capable of a fixed or definite price value, it is being consumed by the beauty or barber shop.

**EXAMPLE:** A car wash purchases water, electricity, or gas used in the washing of a car. The car wash would be the consumer of the water, electricity, or gas and tax is due at the time of purchase. The items purchased by the car wash are not transferred to the customer in a form or quantity capable of a fixed or definite price value, and the customer is not billed for the item.

EXAMPLE: An accounting firm purchases plastic binders which are used to cover the reports issued to its customers. These binders would be subject to tax at the time of purchase by the firm where the customer of the firm is not billed for the item, there being no sale to the customer in such a case.

EXAMPLE: A meat locker purchases materials such as wrapping paper and tape which it uses to wrap meat for customers who provide the locker with the meat. These materials would be subject to tax at the time of purchase by the meat locker because they are not sold to the customer in a form or quantity capable of a fixed or definite price value.

EXAMPLE: A jeweler purchases materials such as main springs and crystals to be used in the performance of a service. These items are purchased by the jeweler for resale where they are transferred to the customer in a form or quantity capable of a fixed or definite price value and each item is actually sold to the customer as evidenced by a separate charge therefor.

EXAMPLE: A lawn care service applies fertilizer, herbicides, and pesticides to its customers' lawns. The following are examples of invoices to customers which are suitable to indicate a lawn care service's purchase of the fertilizer, herbicides, and pesticides for resale to those customers: "Chemicals...31 Gal...\$60"; "Fertilizer...50 lbs....\$100"; and "Materials applied to lawn...4 bushel...\$40". The following are examples of information placed upon an invoice which would not indicate a purchase for resale to the customers invoiced: "Fifty percent of the charge for this service is for materials placed on a lawn," or "Lawn chemicals...\$30" or "Fifty pounds of fertilizer was applied to this lawn."

**18.31(2)** *Purchases made by automobile body shops or garages with body shops (effective October 1, 1980).*

Tangible personal property purchased by body shops can be purchased for resale provided both of the following conditions are met:

1. The property purchased for resale is actually transferred to the body shop's customer by becoming an ingredient or component part of the repair work. See Iowa Code section 422.42(2) and *Cedar Valley Leasing Inc. v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979).

2. The property purchased for resale is itemized as a separate item on the invoice to the body shop's customer and is transferred to the customer in a form or quantity capable of a fixed or definite price value.

If either of the above two events is missing, there is no purchase for resale and the body shop is deemed the consumer of the item purchased.

When body shops purchase items which will be resold (see list of items in this rule) in the course of the repair activity, the vendors selling to the body shops are encouraged to accept a valid resale certificate at the time of purchase. See rule 701—15.3(422,423). Failure of the vendor to accept a valid resale certificate may subject that vendor to sales tax liability since the burden of proof would be on the vendor that a sale was made for resale. If the vendor cannot meet that burden, the vendor will be liable for the sales tax. Such burden is not met merely by a showing that the purchaser had obtained from the department an Iowa retail sales tax or retail use tax permit.

For insurance purposes, body shops are reimbursed by insurance companies for "materials" which such shops consume in rendering repair services. Some of the materials are transferred to the recipients of the repair services and some are not. Of those so transferred, such transfer is in irregular quantities and is not in a form or quantity capable of a fixed or definite price value. Therefore, body shops are generally deemed to be the consumers of materials and must pay tax on these items at the time of purchase. Nonexclusive examples of items most likely to be included in this category of "materials," whether actually transferred to customers of body shops or not, are as follows:

- Abrasives
- Accessories
- Battery water
- Body filler or putty
- Body lead
- Bolts, nuts and washers
- Brake fluid
- Buffing pads

Chamois  
Cleaning compounds  
Degreasing compounds  
Floor dry  
Hydraulic jack oil  
Lubricants  
Masking tape  
Paint  
Polishes  
Rags  
Rivets and cotter pins  
Sand paper  
Sanding discs  
Scuff pads  
Sealer and primer  
Sheet metal  
Solder  
Solvents  
Spark plug sand  
Striping tape  
Thinner  
Upholstery tacks  
Waxes  
White sidewall cleaner

The following are nonexclusive examples of parts which can be purchased for resale since they are generally transferred to the body shop's customer during the course of the repair in a form or quantity capable of a fixed or definite price value and are generally itemized separately as parts.

Batteries  
Brackets  
Bulbs  
Bumpers  
Cab corners  
Chassis parts  
Doors  
Door guards  
Door handles  
Engine parts  
Fenders  
Floor mats  
Grills  
Headlamps  
Hoods  
Hub caps  
Radiators  
Rocker panels  
Shock absorbers  
Side molding  
Spark plugs  
Tires  
Trim  
Trunk lids  
Wheels

Window glass  
Windshield ribbon  
Windshields

The following are nonexclusive examples of tools and supplies which are generally not transferred to the body shop's customer during the course of the repair and therefore could not be purchased for resale. The body shop is deemed the consumer of these items since they are not transferred to a customer and therefore the body shop must pay tax to the vendor at the time of purchase.

Air compressors and parts  
Body frame straightening equipment  
Brooms and mops  
Buffers  
Chisels  
Drill bit  
Drop cords  
Equipment parts  
Fire extinguisher fluids  
Floor jacks  
Hand soap  
Hand tools  
Office supplies  
Paint brushes  
Paint sprayers  
Sanders  
Spreaders for putty  
Signs  
Washing equipment and parts  
Welding equipment and parts

Because of the nature of their business and the formulas devised by the insurance industry to reimburse body shops for cost of "materials," it is possible for body shops, in their invoices to their customers, to separately set forth labor, resold parts, and materials. While the materials can be separately invoiced as one general item, there is no way to ascertain a definite and fixed price for each item of the materials listed in this rule and consumed by the body shops and some of such individual materials are not even transferred by body shops to their customers. Therefore, the body shops are generally the "consumers" of "materials" and do not purchase them for resale. *W. J. Sandberg Co. v. Iowa State Board of Assessments and Review*, 225 Iowa 103, 278 N.W. 643 (1938). Thus, body shops should pay tax to their suppliers on all materials purchased and consumed by them. If materials are purchased from non-Iowa suppliers who do not collect Iowa tax from body shops, such body shops should remit consumer use tax to the Department of Revenue on such materials.

Body shops must collect sales tax on the taxable service of repairing motor vehicles. See rule 701—26.5(422). However, due to the nature of the insurance formulas, it is possible for body shops to itemize that portion of their billing which would be for repair services and that portion relating to consumed "materials." It is also possible for body shops to itemize that portion of their charges for parts which they purchase for resale to their customers. Body shops do not and cannot resell the tools and supplies previously listed in this rule and are taxable on their purchases of such items.

Therefore, as long as body shops separately itemize on their invoices to their customers the amounts for labor, parts, and for "materials," body shops should collect sales tax on the labor and the parts, but not on the materials as enumerated in this rule.

EXAMPLE: A body shop repairs a motor vehicle by replacing a fender and painting the vehicle. In doing the repair work, the body shop uses rags, sealer and primer, paint, solder, thinner, bolts, nuts and washers, masking tape, sandpaper, waxes, buffing pads, chamois, solder and polishes. In its invoice to the customer, the labor is separately listed at \$300, the part (fender) is separately listed at \$300, and the category of "materials" is separately listed for a lump sum of \$100, for a total billing of \$700. The Iowa

sales tax computed by the body shop should be on \$600 which is the amount attributable to the labor and the parts. The materials consumed by the body shop were separately listed and would not be included in the tax base for “gross taxable services” as defined in Iowa Code subsection 422.42(16), which is taxable in Iowa Code section 422.43.

In this example, if the “materials” were not separately listed on the invoice, but had been included in either or both of the labor or part charges by marking up such charges, the body shop would have to collect sales tax on the full charges for parts or labor even though tax was paid on materials by the body shop to its supplier at time of purchase.

This rule is intended to implement Iowa Code sections 422.42, 422.43 and 423.2.

**701—18.32(422,423) Sale, transfer or exchange of tangible personal property or taxable enumerated services between affiliated corporations.**

**18.32(1)** *In general.* The sale, transfer or exchange of tangible personal property or taxable services among affiliated corporations, included but not limited to a parent corporation to a subsidiary corporation, for a consideration is subject to tax. A bookkeeping entry for an “account payable” qualifies as consideration as well as the actual exchange of money or its equivalent. Transactions between affiliated corporations may not be subject to tax where it can be shown that the affiliated corporations are operating as a unit within the meaning of Iowa Code sections 422.42(1) and 423.1(8).

**18.32(2)** *Affiliated corporations acting as a unit.* If an affiliated corporation acts as an agent for the other affiliated corporation in a transaction listed in 18.32(1) such corporation shall be considered as acting as a unit as set forth herein and such transactions may not be subject to tax.

This rule should not be equated with the unitary business concept used in corporation income tax law.

This rule is intended to implement Iowa Code sections 422.42(1) and 423.1(8).

**701—18.33(422,423) Printers’ and publishers’ supplies exemption with retroactive effective date.**

**18.33(1)** For the purposes of this rule, a “printer” is any person, a portion of whose business involves the completion of a finished, printed product for sale at retail by that person or another person. A “printer” is also any person, a portion of whose business involves the completion of a finished printed packaging material used to package products for ultimate sale at retail. The term “printer” does not include any person printing or copyrighting printed material for its own use or consumption and not for resale. A “publisher” means and includes any person who owns the right to produce, market, and distribute printed literature and information for ultimate sale at retail.

**18.33(2)** Effective May 4, 1995, and retroactive to July 1, 1983, the gross receipts from the sale or rental of the following to a printer or publisher are exempt from tax: acetate; antihalation backing; antistatic spray; back lining; base material used as a carrier for light sensitive emulsions; blankets; blow-ups; bronze powder; carbon tissue; codas; color filters; color separations; contacts; continuous tone separations; creative art; custom dies and die cutting materials; dampener sleeves; dampening solution; design and styling; diazo coating; dot etching; dot etching solutions; drawings; drawsheets; driers; duplicate films or prints; electronically digitized images; electrotypes; end product of image modulation; engravings; etch solutions; film; finished art or final art; fix; fixative spray; flats; flying pasters; foils; goldenrod paper; gum; halftones; illustrations; ink; ink paste; keylines; lacquer; lasering images; layouts; lettering; line negatives and positives; linotypes; lithographic offset plates; magnesium and zinc etchings; masking paper; masks; masters; mats; mat service; metal toner; models; modeling; mylar; negatives; nonoffset spray; opaque film process paper; opaquing; padding compound; paper stock; photographic materials: acids, plastic film, desensitizer emulsion, exposure chemicals, fix, developers, paper; photography, day rate; photopolymer coating; photographs; photostats; photo-display tape; phototypesetter materials; pH-indicator sticks; positives; press pack; printing cylinders; printing plates, all types; process lettering; proof paper; proofs and proof processes, all types; pumice powder; purchased author alterations; purchased composition; purchased phototypesetting; purchased stripping and paste-ups; red litho tape; reducers; roller covering; screen tints; sketches; stepped plates; stereotypes; strip types; substrate; tints; tissue overlays; toners; transparencies; tympan;

typesetting; typography; varnishes; Veloxes; wood mounts; and any other items used in a similar capacity to any of the above-enumerated items by the printer or publisher to complete a finished product for sale at retail. Expendable tools and supplies not enumerated in this subrule are subject to tax.

**18.33(3)** Claim for refunds of tax, interest, or penalty paid for the period of July 1, 1983, to June 30, 1995, must be limited to \$25,000 in the aggregate and will not be allowed unless filed prior to October 1, 1995. If the amount of claimed refunds for this period totals more than \$25,000, the department must prorate the \$25,000 among all claims.

**701—18.34(422,423) Automatic data processing.**

**18.34(1)** *In general.*

*a. Applicability of tax.* For the purposes of this rule, the tax on automatic data processing is applicable to the gross receipts of:

- (1) Sales and rentals of data processing equipment (hardware).
- (2) Sales and rentals of tangible personal property produced or consumed by data processing equipment or prewritten (canned) computer software used in data processing operations.
- (3) Certain enumerated services performed on or connected with data processing such as rental of tangible personal property, machine repair, services of machine operators, office and business machines repair, electrical installation, and any other taxable service enumerated in Iowa Code section 422.43.

*b. Definitions.*

(1) “*Computer*” means a programmed or programmable machine or device having information processing capabilities and includes word processing equipment, testing equipment, and programmed or programmable microprocessors and any other integrated circuit embedded in manufactured machinery or equipment.

(2) “*Hardware*” means the physical computer assembly and peripherals including, but not limited to, such items as the central processing unit, keyboards, consoles, monitors, memory, disk and tape drives, terminals, printers, plotters, modems, tape readers, document sorters, optical readers and digitizers.

(3) “*Canned software*” is prewritten computer software which is offered for general or repeated sale or rental to customers with little or no modification at the time of the transaction beyond specifying the parameters needed to make the program run. Canned software is tangible personal property. The term also includes programs offered for general or repeated sale or rental which were initially developed as custom software. Evidence of canned software includes the selling or renting of the software more than once. Software may qualify as custom software for the original purchaser or lessor but is canned software with respect to all others. Canned software includes program modules which are prewritten and later used as needed for integral parts of a complete program.

(4) “*Custom software*” is specified, designed, and created by a vendor at the specific request of a customer to meet a particular need and is considered to be a sale of a service rather than a sale of tangible personal property. It includes those services represented by separately stated charges for the modification of existing prewritten software when the modifications are written or prepared exclusively for a customer. Modification to existing prewritten software to meet the customer’s needs is custom computer programming only to the extent of the modification and only to the extent that the actual amount charged for the modification is separately stated. Examples of services that do not result in custom software include loading parameters to initialize program settings and arranging preprogrammed modules to form a complete program.

When the charges for modification of a prewritten program are not separately stated, tax applies to the entire charge made to the customer for the modified program unless the modification is so significant that the new program qualifies as a custom program. If the prewritten program before modification was previously marketed, the new program will qualify as a custom program if the price of the prewritten program was 50 percent or less of the price of the new program. If the prewritten program was not previously marketed, the new program will qualify as a custom program if the charge made to the customer for custom programming services, as evidenced by the records of the seller, was more than 50 percent of the contract price to the customer.

The department will consider the following records in determining the extent of modification to prewritten software when there is not a separate charge for the modification: logbooks, timesheets, dated documents, source codes, specifications of work to be done, design of the system, performance requirements, diagrams of programs, flow diagrams, coding sheets, error printouts, translation printouts, correction notes, and invoices or billing notices to the client.

(5) “*Storage media*” includes hard disks, compact disks, floppy disks, diskettes, diskpacks, magnetic tape, cards, or other media used for nonvolatile storage of information readable by a computer.

(6) “*Rental*” includes any lease or license agreement between a vendor and a customer for the customer’s use of hardware or software.

(7) “*Program*” is interchangeable with the term “software” for purposes of this rule.

**18.34(2) Taxable sales, rentals and services.**

*a. Sales of equipment.* Tax applies to sales of automatic data processing equipment and related equipment.

*b. Rental or leasing of equipment.* Where a lease includes a contract by which a lessee secures for a consideration the use of equipment which may or may not be used on the lessee’s premises, the rental or lease payments are subject to tax. See rule 701—26.18 on tangible personal property rental.

*c. Canned software.* The sale or rental for a consideration of any computer software which is not custom software is a transfer of tangible personal property and is taxable. Canned software may be transferred to a customer in the form of diskettes, disks, magnetic tape, or other storage media or by listing the program instructions on coding sheets.

(1) Tax applies whether title to the storage media on which the software is recorded, coded, or punched passes to the customer or the software is recorded, coded, or punched on storage media furnished by the customer. A fee for the temporary transfer of possession of canned software for the purpose of direct use to be recorded, coded, or punched by the customer or by the lessor on the customer’s premises, is a sale or rental of canned software and is taxable.

(2) Tax applies to the entire amount charged to the customer for canned software. Where the consideration consists of license fees, royalty fees, right to use fees or program design fees, whether for a period of minimum use or for extended periods, all fees includable in the purchase price are subject to tax.

*d. Training materials.* Persons who sell or lease data processing equipment may provide a number of training services with the sale or rental of their equipment. Training services, per se, are not subject to tax. Training materials, such as books, furnished to the trainees for a specific charge are taxable.

*e. Services a part of the sale or lease of equipment.* Where services, such as programming, training or maintenance services, are provided to those who purchase or lease automatic data processing and related equipment, on a mandatory basis as an inseparable part of the sale or taxable lease of the equipment, charges for the furnishing of the services are includable in the measure of tax from the sale or lease of the equipment whether or not the charges are separately stated. (Where the purchaser or lessee has the option to acquire the equipment either with the services or without the services, charges for the services may not be excluded from the measure of tax if they are taxable enumerated services.)

*f. Materials and supplies.* The transfer of title, for a consideration, of tangible personal property, including property on which or into which information has been recorded or incorporated is a sale subject to tax.

Generally service bureaus are consumers of all tangible personal property, including cards and forms, which they use in providing services unless a separate charge is made to customers for the materials, in which case, tax applies to the charge made for the materials.

*g. Additional copies.* When additional copies of records, reports, tabulation, etc., are sold, tax applies to the charges made for the additional copies. “Additional copies” are all copies in excess of those produced on multipart carbon paper simultaneously with the production of the original and on the same printer, whether the copies are prepared by rerunning the same program, by using multiple simultaneous printers, by looping a program such that the program is run continuously, by using different programs to produce the same output product, or by other means. Where additional copies are prepared, the tax will be measured by the charge made by the service bureau to the customer. If no separate charge is made

for the additional copies, tax applies to that portion of the gross receipts which the cost of the additional computer time (if any) and the cost of materials and labor cost to produce the additional copies bear to the total job cost. Charges for copies produced by means of photocopying, multilithing, or by other means are subject to tax. Tax applies to a contract where data on magnetic tape are converted into combinations of alphanumeric printing, curve plotting or line drawings, and put on microfilm or photorecording paper.

*h. Mailing lists.* Addressing (including labels) for mailing. Where the service bureau addresses, through the use of its automatic data processing equipment or otherwise, material to be mailed, with names and addresses furnished by the customer or maintained by the service bureau for the customer, tax does not apply to the charge for addressing. Similarly, where the service bureau prepares, through the use of its automatic data processing equipment or otherwise, labels to be affixed to material to be mailed, with names and address furnished by the customer or maintained by the service bureau for the customer, tax does not apply to the charge for producing the labels, regardless of whether the service bureau itself affixes the labels to the material to be mailed. However, tax would be due on any tangible personal property, such as labels, consumed by the service bureau. (See “*f*” above.) Mailing lists in the form of Cheshire tapes, gummed labels, and heat transfers which are attached to envelopes and placed in the mail by a service bureau constitute tangible personal property and are subject to tax.

*i. Services of a machine operator.* The services of a machine operator, such as a key punch operator or the operator of any other data processing equipment, when hired to operate another person’s machinery or equipment, are subject to tax when contracted for and performed by someone other than an employee of the owner of the machinery and equipment.

*j. Maintenance contracts.* Maintenance contracts sold in connection with the sale or lease of canned software generally provide that the purchaser will be entitled to receive storage media on which prewritten program improvements have been recorded. The maintenance contract may also provide that the purchaser will be entitled to receive certain services, including error corrections and telephone or on-site consultation services.

(1) Nonoptional maintenance contract. If the maintenance contract is required as a condition of the sale or rental of canned software, it will be considered as part of the sale or rental of the canned software, and the gross sales price is subject to tax whether or not the charge for the maintenance contract is separately stated from the charge for software.

(2) Optional maintenance contracts prior to July 1, 1998. If the maintenance contract is optional to the purchaser of canned software, then only the portion of the contract fee representing improvements delivered on storage media is subject to sales tax if the fee for other services, including consultation services and error corrections, is separately stated. If the fee for other services, including consultation services and error corrections, is not separately stated from the fee for improvements delivered on storage media, the entire charge for the maintenance contract is subject to sales tax.

(3) Optional maintenance contracts on and after July 1, 1998. If an optional software maintenance or support contract provides for technical support services only, then no tax is imposed on the gross receipts from the performance of those services. If an optional software maintenance or support contract separately states the charges which represent improvements delivered on storage media from charges which represent other services, including consultation services and error correction, then only that portion of the contract fee representing improvements delivered on the storage media is subject to sales tax. If an optional software maintenance or support contract provides for the taxable transfer of tangible personal property and the provision of nontaxable services, and there is no separately stated charge for the taxable transfer of property or for the nontaxable service, then state sales tax of 5 percent shall be imposed on 50 percent of the gross receipts from the sale of such contracts. See 701—paragraph 18.25(3)“*c*” for more information.

**18.34(3) Nontaxable items and activities.**

*a. Custom programs.* These are programs prepared to the special order of a customer. Tax does not apply to the transfer of custom programs in the form of written procedures, such as program instructions listed on coding sheets. Tax applies to the sale of material transferred to the customer in the form of typed or printed sheets if separately invoiced.

*b. Processing a client's data.* Generally speaking, if a person enters into a contract to process a client's data by the use of a computer program, or through an electrical accounting machine programmed by a wired plugboard, the processing of a client's data is nontaxable. Such contracts usually provide that the person will receive the client's source documents, record data in machine readable form, such as in punch cards or on magnetic tape, make necessary corrections, rearrange or create new information as the result of the processing and then provide tabulated listings or record output on other media. This service will be considered nontaxable even if the total charge is broken down into specific charges for each step. The furnishing of computer programs and data by the client for processing under direction and control of the person providing the service is nontaxable even though charges may be based on computer time. The true object of these contracts is considered to be a service, even though some tangible personal property is incidentally transferred to the client. However, tax will apply to tangible personal property separately invoiced to the client.

*c. Time sharing.* Charges made for the use of automatic data processing equipment, on a time-sharing basis, where access to the equipment is by means of remote facilities, are not subject to tax. Time sharing which is, in fact, a rental of equipment and the lessee exercises the right of possession or control over the equipment is subject to tax. See 18.34(2) "b" and rule 701—26.18(422).

*d. Designing of systems, converting of systems, consulting, training, and miscellaneous services.* These services consist of the developing of ideas, concepts and designs. Common examples of these nontaxable services are:

(1) Designing and implementing computer systems (e.g., determining equipment and personnel required and how they will be utilized).

(2) Designing storage and data retrieval systems (e.g., determining what data communications and high speed input-output terminals are required).

(3) Converting manual systems to automatic data processing systems, converting present automatic data processing systems to new systems (e.g., changing a second generation system to a third generation system).

(4) Consulting services (e.g., studies of all or part of a data processing system).

(5) Feasibility studies (e.g., studies to determine what benefits would be derived if procedures were automated).

(6) Evaluation of bids (e.g., studies to determine which manufacturer's proposal for computer equipment would be most beneficial).

(7) Providing technical help such as analysts and programmers, usually on an hourly basis.

(8) Writing (coding) and testing of programs—contract programming. These services result in the production of customized programs. This type of service is not taxable because programming requires the development or ascertainment of information, and the evaluation of data, in addition to other development skills.

Persons engaged in providing nontaxable computer services are the consumers of all tangible personal property used in such activities, and the tax must be paid on their acquisition of such property.

This paragraph, 18.34(3) "d," shall become effective for periods beginning on or after April 1, 1992.

*e. Installation charges.* Where installation charges are separately contracted for or where no contract exists, are separately invoiced, or do not constitute enumerated taxable services, they are exempt from tax. See rule 701—15.14(422,423).

*f. Pickup and delivery charges.* The tax will not apply to pickup and delivery charges which are separately contracted for or where no contract exists, are separately invoiced.

*g. Rental of computer programs.* Prior to July 1, 1984, the rental of computer programs was not subject to tax since the program did not constitute equipment. *KTVO, Inc. vs. Bair*, 1977, Iowa 225 N.W.2d, 111. For the rule regarding prewritten (canned) programs subsequent to that date, see 18.3(2) "c."

This rule is intended to implement Iowa Code sections 422.42, 422.45 and 423.2 and Iowa Code Supplement section 422.43 as amended by 1998 Iowa Acts, Senate File 2288.

**701—18.35(422,423) Drainage tile.** The sale or installation of drainage tile which is to be used in disease control, weed control, or the health promotion of plants or livestock produced as part of agricultural production for market is exempt from tax. Drainage tile, when purchased for these purposes, is therefore not subject to tax. In all other cases, drainage tile will be considered a building material and subject to tax under the provisions of Iowa Code subsection 422.42(9).

This rule is intended to implement Iowa Code sections 422.42(3), 422.42(9), and 423.2.

**701—18.36(422,423) True leases and purchases of tangible personal property by lessors.**

**18.36(1) True leases and purchases by lessors prior to, on, and subsequent to July 1, 1978.** The definition of a sale specified in Iowa Code subsection 422.42(2) does not include leases. Hence, the exemption from tax on sales for resale is inapplicable to the purchase of tangible personal property for the purpose of leasing such property to others, but not for the purpose of reselling such property. *Cedar Valley Leasing, Inc. v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979). However, even though the general rule is that the acquisition cost of tangible personal property purchased for the purpose of leasing it to others is subject to the Iowa sales or use tax, certain transactions are exempted from tax by statute. See subrule 18.36(4).

**18.36(2) General.** Prior to July 1, 1984, tax is due on the lease or rental payments derived from the service of equipment rental only and not from the lease or rental of other tangible personal property. See 701—subrule 26.18(1). Tax would also be due on the gross receipts received on the disposal of the tangible personal property provided no exemption exists. When property is purchased for the purpose of financing under a conditional sales contract, the property is purchased for resale, and the acquisition of the property is not subject to Iowa tax. See rule 701—16.47(422,423).

The gross receipts from the leasing of property for subletting purposes is exempt from tax as a resale of a service, but the lessee must collect tax on the gross receipts from subletting unless such subletting is otherwise exempt from tax.

*a.* Where a resident or nonresident lessor leases equipment to a resident or nonresident lessee and the lease contract is executed in Iowa and the equipment is delivered to the lessee in Iowa, the rental payments are subject to Iowa sales tax, even if the equipment is taken by the lessee to another state. *Williams Rentals, Inc. v. Tidwell*, 516 S.W.2d 614 (Tenn. 1974).

*b.* Where a nonresident lessor leases equipment to a resident or nonresident lessee and the lessee uses the equipment in Iowa, the nonresident lessor has the responsibility of collecting Iowa use tax on the lease payments, provided the lessor maintains a place of business in Iowa as provided in Iowa Code sections 423.1(6) and 423.9. Whether the lease agreement is executed in Iowa or not is irrelevant. *State Tax Commission v. General Trading Co.*, 322 U.S. 335, 64 S.Ct. 1028, 88 L.Ed 1309, (1944).

*c.* Where a lessee is the recipient of equipment rental services as defined in “*a*” and “*b*” above and no tax has been collected from such lessee by the lessor, the lessee should remit Iowa use tax to the department of revenue. In the event no tax is remitted, the department, in its discretion, may seek to collect the tax from the lessor or lessee. In the event that the lessee is the recipient of equipment rental services, and the lessor does not maintain a place of business in Iowa and does not collect use tax pursuant to Iowa Code section 423.10, such lessee shall remit tax on its rental payments to the department.

*d.* Where a resident lessor leases equipment to a nonresident lessee outside of Iowa, and the equipment is delivered to the lessee outside Iowa, the act of leasing is exempt from the Iowa sales tax on the rental payments. However, in the event the lessee brings the equipment into Iowa and uses it in Iowa, Iowa use tax applies to rental payments, but see “*g*” below.

*e.* Where a resident or nonresident lessor purchases tangible personal property in Iowa for subsequent lease in or out of Iowa and takes delivery of the equipment in Iowa, the lessor’s purchase is subject to Iowa sales tax. *Dodgen Industries, Inc. v. Iowa State Tax Commission*, 160 N.W.2d 289 (Iowa 1968).

*f.* When a resident or nonresident lessor purchases tangible personal property outside of Iowa for the purpose of leasing it in Iowa and the equipment is brought into Iowa and used by the resident or nonresident lessee in this state, the lessor is considered as having a “use” of the property in Iowa and Iowa use tax will apply to the lessor’s purchase price of the property, regardless whether or not the lessor

makes any physical use of the property in Iowa. *Union Oil Company of California v. State Board of Equalization*, 1963, 34 Cal. Rpts. 872, 386 P.2d 496.

g. If a sales or use tax has already been paid to another state on the purchase price of equipment prior to the use of that equipment in Iowa, a tax credit against the Iowa use tax on the purchase price will be given. After the equipment is brought into Iowa, if a sales or use tax is properly payable and is paid to another state on the rental payments of equipment, for the same time the Iowa tax is imposed on such rentals, a tax credit against the Iowa use tax on such rental payments will be given. *Henneford v. Silas Mason Co.*, 1937, U.S.577, 57 S.Ct. 524, 51 L.Ed. 814.

**18.36(3)** *Leases relating to vehicles subject to registration.*

a. Vehicles as defined in Iowa Code subsections 321.1(4), (6), (8), (9), and (10) (motor trucks, truck tractors, road tractors, trailers, and semitrailers), except when designed primarily for carrying persons, can be purchased free of use tax when purchased for lease and actually leased for use outside Iowa if the subsequent sole use in Iowa is in interstate commerce or interstate transportation.

b. Tangible personal property which by means of fabrication, compounding, or manufacturing becomes an integral part of vehicles as defined in 18.36(3)“a” when manufactured for lease and actually leased to a lessee for use outside the state of Iowa, can be purchased free of use tax provided the sole subsequent use of the vehicle in Iowa is in interstate commerce or interstate transportation. (Iowa purchases which would be subject to Iowa sales tax do not qualify for this exemption.) See rule 701—33.7(423).

The provisions of “a” and “b” are effective for periods beginning on January 1, 1973. Also see 701—Chapter 34 of the rules relating to vehicles subject to registration.

**18.36(4)** *Special rules for lessors on or after July 1, 1978.* If tangible personal property is purchased for leasing, the purchase of the property is exempt from tax if the following conditions are met:

- a. The person (lessor) purchasing the property is regularly engaged in the business of leasing,
- b. The period of the lease is for more than one year for sales or property occurring from July 1, 1978, to May 18, 1997, inclusive; for sales of property occurring on and after May 19, 1997, the period of the lease must be for more than five months, and
- c. The lease or rental receipts must be subject to tax under the service of equipment rental.

All three conditions must be met before the exemption applies.

If the exemption is properly claimed, it is lost when the property is made use of for any purpose other than leasing and the person claiming the exemption is liable for the tax based on the original purchase price. Tax paid on the leasing or rental payments would be allowed as a credit against the tax due on the purchase price.

In the following examples, assume, unless stated to the contrary, that the lease or rental receipts are subject to tax. The examples are written on the assumption that the period for an exempt lease is five months or longer. Thus, these examples are basically applicable to the period beginning May 19, 1997; however, the examples illustrate principles which are applicable to the purchase for lease exemption for periods longer than one year which was the requirements for exemption prior to May 19, 1997.

EXAMPLE: A restaurant makes a one-time purchase of office furniture which it leases to an insurance company for a period of four years. The purchase of office furniture by the restaurant would be subject to tax because the restaurant is not regularly engaged in the business of leasing. However, if the restaurant established a pattern of regularly purchasing office furniture or other tangible personal property for lease, the exemption would apply.

EXAMPLE: A company purchases a computer which will be leased for a period of three years, at which time the computer is returned to the company. The sole business of the company is to purchase this one computer for lease. The purchase of the computer is exempt from tax because the company is regularly engaged in the business of leasing.

EXAMPLE: A leasing company purchases three lawn mowers which will be leased to individuals for periods of time less than five months. The purchase of the lawn mowers by the leasing company would be subject to tax because the periods of the leases are for less than five months.

EXAMPLE: A leasing company purchases a computer which will be leased for a period of three years. The purchase of the computer is exempt from tax because the period of the lease is for more than five months.

EXAMPLE: A leasing company buys a computer. The company claims the exemption from tax, but the company uses the computer in its own operations. Tax is due on the original purchase price and the leasing company is liable for the tax due.

EXAMPLE: A leasing company purchases a copying machine which will be leased for a period of two years. After four months, the machine is returned to the leasing company and then the machine is immediately re-leased without being used by the leasing company for any other purpose. The exemption would apply because it was properly claimed and nothing occurred to cause loss of the exemption.

EXAMPLE: A leasing company purchases a copying machine which will be leased for a period of two years. After four months, the machine is returned and the leasing company then uses the machine in its own business. The exemption would no longer apply and the leasing company would be liable for the tax based on the original purchase price. Credit would be allowed against the tax due on the purchase price for any tax paid on the lease or rental payments. Assume the leasing company paid \$2,000 for the copying machine and charged \$200 per month plus \$10 in tax per month. Since the machine is returned and the exemption is not applicable, the leasing company would owe \$100 on the \$2,000 acquisition cost. However, the leasing company collected \$40 (four months x \$10) tax on the monthly rental charges. Allowing the credit for tax collected of \$40 against the total tax liability of \$100 leaves a net tax liability of \$60 owed by the leasing company.

EXAMPLE: A manufacturer and seller of office furniture also leases office furniture. The leases always run for a period longer than five months and the company usually has only two leases per year. The leasing operation only accounts for 1 percent of the company's total business. The company still qualifies for the exemption because it is regularly engaged in the business of leasing and the period of the lease is for more than five months.

EXAMPLE: A leasing company purchases an airplane from an aircraft dealer and leases it for a period of three years. The lease or rental payments are not taxed because of the exemption for transportation services. The leasing company would owe tax based on the acquisition cost because the lease or rental payments are not subject to tax under the service of equipment rental.

EXAMPLE: A leasing company purchases equipment and leases it to a lessee for a period of 18 months. For the first 3 months, the equipment is used by the lessee in making repairs to existing structures and the lease receipts are taxable. For the remainder of the lease period, the equipment is used in new construction of buildings and structures and the lease receipts are exempt from tax. The acquisition cost of the equipment is exempt because the exemption was properly claimed and was not subsequently lost by a use other than leasing.

EXAMPLE: A leasing company purchases from an Iowa retailer equipment on May 18, 1997, for the purpose of leasing it for a period of six months. The lease receipts will be taxable. The sales tax exemption on the acquisition cost to the lessor cannot be claimed because the sale occurred before May 19, 1997, and, at the time of the sale, no sales tax exemption applied to such acquisition cost. The exemption for acquisition cost should not be given a retroactive effect. *Jones v. Gordy*, 1935, 169 Md. 173, 180 Atl. 272.

EXAMPLE: A leasing company purchases equipment outside of Iowa on May 1, 1997. The lessee brings the equipment into Iowa on June 1, 1997, and uses it in Iowa. The lease period is nine months, and the lessee's use in Iowa is subject to Iowa use tax on the lease payments. Under these circumstances, the Iowa use tax exemption on the lessor's acquisition cost applies because it is the law in effect at the time of use in Iowa, not at the time of sale, which determines whether a use tax exemption applies. *City of Ames v. Iowa State Tax Commission*, 1955, 246 Iowa 1016, 71 N.W.2d 15; *Allis-Chalmers Mfg. Co. v. Iowa State Tax Commission*, 1958, 250 Iowa 193, 92 N.W.2d 129.

EXAMPLE: A leasing company purchases equipment not for resale and leases it to the lessee for a period of more than five months. After three months, the equipment is returned to the leasing company which then sells the equipment. Such sale is not part of the regular course of the leasing company's business. The exemption, though properly claimed, is lost because, by reason of such sale, the leasing

company made use of the property for a purpose other than leasing or renting. Had the equipment been returned to the leasing company on or after five months and one day from the commencement of the lease period, and the leasing company then sold the equipment outside the regular course of its business or used the equipment in its business, the exemption for acquisition cost would not be lost. Had the equipment been purchased for resale and leased prior to such resale, the acquisition cost to the leasing company would be exempt from tax. *Herman M. Brown Co. v. Johnson*, 1957, 248 Iowa 1143, 82 N.W.2d 134. If the equipment is traded in toward the purchase price of other equipment by the leasing company, or if the leasing company disposes of the equipment after it is fully depreciated, the exemption for acquisition cost is not lost. Where sale of equipment outside the regular course of business is made by the leasing company, see also rule 18.28(422) to determine whether the casual sale exemption applies to the receipts from such sale.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee. Assume that the exemption for acquisition cost of the equipment was properly claimed. Thereafter, the lessee makes an assignment of the lease. The exemption is not lost since the assignee stands in the same position as the original lessee and such an assignment does not change the nature of the original lease period. *Berg v. Ridgway*, 1966, 258 Iowa 640, 140 N.W.2d 95.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee in accordance with the criteria creating the acquisition cost exemption. The leasing company sells the lease contracts, as commercial paper, to others. The exemption for acquisition cost can still be claimed and such sales of lease contracts do not cause loss of the exemption.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee in accordance with the criteria creating the acquisition cost exemption. Thereafter, the lease can no longer be performed because the property is destroyed by an act of God. The acquisition cost exemption is not lost.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee in accordance with the criteria creating the acquisition cost exemption. Thereafter, the lessee is adjudged bankrupt and the equipment is returned to the leasing company and is re-leased without being used by the leasing company for any other purpose. The acquisition cost exemption is not lost since the leasing company makes no use for any purpose other than leasing or renting.

EXAMPLE: A leasing company purchases equipment which is leased to a lessee. The criteria for the acquisition cost exemption are present. The lessee then sublets the equipment to another for a period less than five months. The acquisition cost exemption is not lost.

**18.36(5)** *Lease or rental of all tangible personal property now subject to tax.* On and after July 1, 1984, the lease or rental of all tangible personal property is subject to tax. See rule 701—26.18(422) for information concerning additional transactions subject to tax after that effective date.

This rule is intended to implement Iowa Code sections 422.42(2), 422.43, 422.45, 423.1, and 423.4.

### **701—18.37(422,423) Motor fuel, special fuel, aviation fuels and gasoline.**

**18.37(1)** *In general.* The gross receipts from the sale of motor fuel and special fuel are exempt from sales tax under Iowa Code section 422.45(11) if (1) the fuel is consumed for highway use, in watercraft, or in aircraft, (2) the Iowa fuel tax has been imposed and paid, and (3) no refund or credit of fuel tax has been made or will be allowed. However, beginning July 1, 1985, the gross receipts from the sale of special fuel for diesel engines used in commercial watercraft on rivers bordering Iowa are exempt from sales tax, even though no fuel tax has been imposed and paid, providing the seller delivers the fuel to the owner's watercraft while it is afloat. Prior to July 1, 1988, retail sales of aviation gasoline were not exempt from sales tax under Iowa Code subsection 422.45(11). See subrule 18.37(4).

**18.37(2)** *Refunds or credits of motor fuel and special fuel.* Claims for refund or credit of fuel taxes under the provisions of Iowa Code chapter 452A must be reduced by any sales or use tax owing the state unless a sales tax exemption is applicable. Generally, refund claims or credits are allowed where fuel is purchased tax paid and used for purposes other than to propel a motor vehicle or used in watercraft.

**18.37(3)** *Refunds of tax on fuel purchased in Iowa and consumed out of Iowa.* Even though fuel is purchased in Iowa, fuel tax paid in Iowa, and the fuel tax is subject to refund under the provisions of division III of Iowa Code chapter 452A relating to interstate motor vehicle operations, the refund of

the fuel tax does not subject the purchase of the fuel to sales tax. Subjecting the purchase to sales tax has the effect of imposing sales tax when fuel is consumed in interstate commerce while fuel consumed on Iowa highways in intrastate commerce is exempt from sales tax pursuant to Iowa Code subsection 422.45(11). The effect for sales tax purposes is to impose a greater tax burden on non-Iowa highway fuel consumption than Iowa highway fuel consumption thereby discriminating against interstate commerce. In addition, the effect of imposing sales tax on interstate excess purchases where intrastate highway use is not subject to the tax constitutes an export duty for purchasing fuel in Iowa and exporting it for use in another state. Such effects are in violation of the commerce clause of the United States Constitution. *Boston Stock Exchange v. State Tax Commission*, 1977, 429 U.S. 319, 97 S.Ct. 599, 50 L.Ed.2d 514 and *Coe v. Errol*, 1886, 116 U.S. 517, 6 S.Ct. 475, 29 L.Ed. 715.

**18.37(4) Aviation gasoline.** Tax treatment prior to July 1, 1988. Prior to July 1, 1988, all Iowa fuel tax paid on aviation gasoline used in aircraft was refundable under Iowa Code section 452A.17. Generally, aviation gasoline is not purchased for highway use or for use in watercraft, therefore, the exemption from sales and use tax found in Iowa Code subsection 422.45(11) was generally not applicable to purchases of aviation gasoline. However, Iowa Code subsection 422.52(4) provides for the collection of sales tax by way of deduction from motor fuel tax refunds allowable under Iowa Code chapter 452A. Therefore, sales tax is not assessed at the retail level but only in instances where the fuel tax paid on aviation gasoline has been refunded. If no application for a fuel tax refund relating to aviation fuel has been made, no sales tax is assessed on the aviation gasoline purchase.

**18.37(5) Ethanol.** For tax periods after April 30, 1981. Retail sales of ethanol are exempt from Iowa sales or use tax.

**18.37(6) Tax base.** The basis for computing the Iowa sales tax will be the retail selling price of the fuel less any Iowa fuel tax included in such price. Federal excise tax should not be removed from the selling price in determining the proper sales tax due. *W.M. Gurley v. Army Rhoden* supra. Also see rule 701—15.12(422,423).

This rule is intended to implement Iowa Code sections 422.31, 422.43, 422.45(11), 422.45(22), 422.52(4), 423.1, 452A.3, and 452A.17.

**701—18.38(422,423) Urban transit systems.** A privately owned urban transit system which is not an instrumentality of federal, state or county government is subject to sales tax on fuel purchases which are within the urban transit systems charter.

Tax shall not apply to fuel purchases, made by a privately owned urban transit company, for use outside the urban transit system charter in which a fuel tax has been imposed and paid and no refund has been or will be allowed.

Whether an urban transit company will be considered an instrumentality of federal, state or county government for the purpose of receiving sales tax exemption on its fuel purchases, which are also exempted from fuel tax and used for public purposes, depends upon consideration of the following:

1. Whether it is created by government.
2. Whether it is wholly owned by government.
3. Whether it is operated for profit.
4. Whether it is primarily engaged in the performance of some essential governmental function.
5. Whether the payment of tax will impose an economic burden upon the corporation, or that payment of tax serves to materially impair the usefulness or efficiency of the corporation or the payment of tax materially restricts the corporation in the performance of its duties.

These above enumerated considerations are not all inclusive and the presence of some and absence of others does not necessarily establish the exemption. *Unemployment compensation of North Carolina v. Wachovia Bank and Trust Company*, 2 S.E.2d 592, 595, 215 No. Car. 491 (1939); 1976 O.A.G. 823, 827, 828.

This rule is intended to implement Iowa Code subsection 422.45(1).

**701—18.39(422,423) Sales or services rendered, furnished, or performed by a county or city.** The gross receipts from the sales, furnishing, or service of gas, electricity, water, heat, and communication

service rendered, furnished, or performed by a county or city are subject to the tax. On and after July 1, 1985, the gross receipts from fees paid to cities and counties for the privilege of participating in any athletic sports are also subject to tax. On or after July 1, 1991, the gross receipts from any municipally owned pay television service are taxable as well. On and after April 1, 1992, the gross receipts from a county or municipality furnishing sewage service or solid waste collection and disposal service to nonresidential commercial operations are taxable (see rules 701—26.71(422,423) and 26.72(422,423) for more information).

Any other sales or services rendered, furnished, or performed by a county or city are not subject to the tax.

A “sport” is any activity or experience which involves some movement of the human body and gives enjoyment or recreation. An “athletic” sport is any sport which requires physical strength, skill, speed, or training in its performance. The following activities are nonexclusive examples of athletic sports: baseball, football, basketball, softball, volleyball, golf, tennis, racquetball, swimming, wrestling, and foot racing.

The following is a list of various fees which would be considered fees paid to a city or county for the privilege of participating in any athletic sport, and thus subject to tax under this rule. The list is not exhaustive.

1. Fees paid for the privilege of using any facility specifically designed for use by those playing an athletic sport: fees for use of a golf course, ball diamond, tennis court, swimming pool, or ice skating rink are subject to tax. These fees are subject to tax whether they allow use of the facility for a brief or extended period of time, e.g., a daily fee or season ticket for use of a swimming pool or golf course would be subject to tax. Group rental of facilities designed for playing an athletic sport would also be subject to tax.

2. Fees paid to enter any tournament or league which involves playing an athletic sport would be subject to tax. Both team and individual entry fees are taxable. Fees paid to enter any marathon or foot race of shorter duration would be subject to tax under this rule.

Not subject to tax as fees paid to a city or county for the privilege of participating in any athletic sport under this rule are the following charges. The list is not intended to be exhaustive.

1. Fees paid for lesson or instruction in how to play or to improve one’s ability to play an athletic sport are not subject to tax. Golf and swimming lesson fees are specific examples of such nontaxable charges. The fees are excluded from tax regardless of whether the person receiving the instruction is a child or an adult. Fees charged for equipment rental, regardless of whether this equipment is helpful or necessary to participation in an athletic sport, are not subject to tax. The rental of a golf cart or moveable duck blind would not be subject to tax. The rental of a recreational boat is a transportation service, the gross receipts of which are not subject to tax if provided by a city or county.

2. Sales of merchandise, e.g., food or drink, to persons watching or participating in any athletic sport are not subject to tax.

3. Fees charged to improve any facility where any athletic sport is played are not subject to tax, unless such a fee must be paid to participate in an athletic sport which can be played within the facility.

4. Fees paid by any person or organization to rent any county or city facility or any portion of any county or city park shall not be subject to tax unless the portion of the park or facility is specifically designed for the playing of an athletic sport.

EXAMPLE: A local bridge club pays a fee to use a shelter house and the surrounding grounds at a county park for a picnic. During the course of the picnic, the club members set up a net and use the surrounding grounds to play volleyball. They also improvise a softball field and play a softball game there. The fee which the bridge club has paid to rent the shelter house and surrounding grounds would not be subject to tax.

5. Fees paid for the use of a campground or hiking trail are not subject to tax.

This rule is intended to implement Iowa Code sections 422.43 and 422.45.

**701—18.40(422,423) Renting of rooms.** The gross receipts from the renting of any and all rooms, including but not limited to sleeping rooms, banquet rooms or conference rooms in any hotel, motel,

inn, public lodging house, rooming or tourist court, or in any place where sleeping accommodations are furnished to transient guests, whether with or without meals, are subject to the tax. The rental of a mobile home or of manufactured housing which is tangible personal property is treated as room rental rather than tangible personal property rental. The renting of all rooms would be exempt from the tax if rented by the same person for a period of more than 31 consecutive days. The renter must contract to rent for a single period of 31 days or more. The renter may not accumulate these 31 days by contracting for two or more rental transactions. The incremental manner in which the hotel, motel, inn, public lodging house, rooming or tourist court, or any place where sleeping accommodations are furnished to transient guests bills its customers does not influence the accumulation of days that is required to claim the exemption.

This rule is intended to implement Iowa Code section 422.43.

#### **701—18.41(422,423) Envelopes for advertising.**

**18.41(1)** Some envelopes which contain advertising are exempt from tax. Envelopes which are not primarily used for advertising are taxable. The primary use of the envelopes should control whether they will be taxable or exempt. *Iowa Movers and Warehouseman's Assn. v. Briggs*, 237 N.W.2d 759 (Iowa 1976).

EXAMPLE 1: XYZ mails coupons and advertisements to persons giving discounts on a certain item which is sold at retail. The envelope used to package these materials is exempt from tax since it is primarily used to contain advertising materials.

EXAMPLE 2: XYZ mails a monthly billing statement to its charge account customers. In addition to the billing statement, XYZ Company encloses an advertisement in the envelope. The envelope has a dual purpose: (1) the collection of accounts receivable and (2) the distribution of advertising. However, the envelope is not primarily used for advertising but for billing the customer, therefore, the exemption does not apply.

**18.41(2)** Because of the difficulty of administering this exemption, purchasers of envelopes may petition to the department for permission to use a formula to represent to the seller the portion of taxable and exempt gross receipts from envelope purchases.

This rule is intended to implement Iowa Code subsection 422.45(9).

#### **701—18.42(422,423) Newspapers, free newspapers and shoppers' guides.**

**18.42(1) General observations.** The gross receipts from the sales of newspapers, free newspapers, and shoppers' guides are exempt from tax. The gross receipts from the sales of magazines, newsletters, and other periodicals which are not newspapers are taxable. Recent cases decided by the United States Supreme Court and the Supreme Court of Iowa prohibit exempting from taxation the sale of any periodical if that exemption from taxation is based solely upon the contents of that periodical. See *Arkansas Writers' Project, Inc. v. Ragland*, 481 U.S. 221, 107 S.Ct. 1722, 95 L.Ed.2d 209 (1987) and *Hearst v. Iowa Department of Revenue & Finance*, 461 N.W.2d 295 (Iowa 1990).

**18.42(2) General characteristics of a newspaper.** "Newspaper" is a term with a common definition. A "newspaper" is a periodical, published at short, stated, and regular intervals, usually daily or weekly. It is printed on newsprint with news ink. The format of a newspaper is that of sheets folded loosely together without stapling. A newspaper is admitted to the U.S. mails as second-class material. Other frequent characteristics of newspapers are the following:

*a.* Newspapers usually contain photographs. The photographs are more often in black and white rather than color.

*b.* Information printed on newspapers is usually contained in columns on the newspaper pages.

*c.* The larger the cross section of the population which reads a periodical in the area where the periodical circulates, the more likely it is that the department will consider that periodical to be a "newspaper."

**18.42(3) Characteristics of newspaper publishing companies.** Companies in the business of publishing newspapers are differently structured from other companies. Often, companies publishing larger newspapers will subscribe to various syndicates or "wire services." A larger newspaper will employ a general editor and a number of subordinate editors as well, for example, sports and lifestyle

editors; business, local, agricultural, national, and world news editors; and editorial page editors. A larger newspaper will also employ a variety of reporters and staff writers. Smaller newspapers may or may not have these characteristics or may consolidate these functions.

**18.42(4) Characteristics which distinguish a newsletter from a newspaper.** A “newsletter” is generally distributed to members or employees of a single organization and not usually to a large cross section of the general public. It is often published at irregular intervals by a volunteer, rather than the paid individual who usually publishes a newspaper. A newsletter is often printed on sheets which are held together at one point only by a staple, rather than folded together.

This rule is intended to implement Iowa Code section 422.45(9).

**701—18.43(422,423) Written contract.** On and after July 1, 1985, the gross receipts from certain additional services are subject to tax. However, these newly taxable services are exempt from tax if performed pursuant to a written services contract in effect on April 1, 1985. The exemption from taxation for these services expires June 30, 1986. The services to which this “written contract” exemption is applicable are the following: cable television; campgrounds; gun repair; janitorial and building maintenance or cleaning; lawn care, landscaping and tree trimming and removal; lobbying service; pet grooming; reflexology; security and detective services; tanning beds or salons; water conditioning and softening; the rental of recreational vehicles, recreational boats or motor vehicles subject to registration which are registered for a gross weight of 13 tons or less; and fees paid to cities and counties for the privilege of participating in any athletic sports.

A “written contract” is one which is entirely in writing, so that all of its essential terms and provisions exist in writing, and oral statements are not necessary to set out any essential term or provision, such as who the parties to the contract are or what their rights and duties are under the contract. However, if it is necessary to resort to oral statements to explain the meaning of a written provision in a contract, a “written contract” can still exist. A written contract need not consist of one document or instrument only. It can consist of two or more writings, if all the necessary provisions of the contract are contained in those writings. For the purposes of this rule, the following must be stated in writing if a written contract is to exist: The nature and specification of the service to be provided, the name of the party providing the service, the name of the party receiving the service, the “consideration” (amount and method of payment) for providing the service, the signature of one or both of the parties to the contract, depending upon circumstances, and the date upon which the contract became effective.

The written contract must be in effect on April 1, 1985, if the service to which the contract pertains is to be exempt from tax. If a contract is signed by only one of the parties to it, that contract is still a “written contract” if the party which has not signed the contract acquiesces in the promises which the party who has signed the document makes within it. *McDermott v. Mahoney*, 139 Iowa 292, 115 N.W. 32, (Iowa 1908).

EXAMPLE: A security agency sends a proposed agreement to a potential customer promising to provide the services of a uniformed security guard for the customer’s business premises beginning March 15, 1985, and continuing until March 15, 1987. The agreement is signed by the security agency’s president and dated February 15, 1985. The agreement is received by the potential customer’s president, who does not sign it, but, on March 15, 1985, allows the security agency’s uniformed guard on the premises, and makes payment for those services as stipulated in the agreement. This agreement is a “written contract”; the services of the uniformed guard are not subject to tax for the period beginning July 1, 1985, and ending June 30, 1986. The services performed between July 1, 1986, and March 15, 1987, would be subject to tax.

This rule is intended to implement Iowa Code subsection 422.43(11).

**701—18.44(422,423) Sale or rental of farm machinery and equipment.** On and after July 1, 1987, the gross receipts from the sale or rental of farm machinery and equipment will be exempt from tax. Effective July 1, 1996, the gross receipts from the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case or other similar article or receptacle sold for use in agricultural, livestock or dairy production are not subject to sales tax.

**18.44(1) Characteristics of and limitations upon farm machinery and equipment.** To be eligible for exemption from or refund of tax under this rule the machinery or equipment must:

- a. Be directly and primarily used in production of agricultural products; and
- b. Be one of the following:
  - (1) A self-propelled implement; or
  - (2) An implement customarily drawn or attached to a self-propelled implement; or
  - (3) A grain dryer; or
  - (4) An auxiliary attachment which improves the performance, safety, operation, or efficiency of a qualifying implement or grain dryer if sale or first use in Iowa is on or after July 1, 1995; or
  - (5) A replacement part for any item described in subparagraph (1), (2), (3), or (4).
  - (6) Effective July 1, 1996, the gross receipts from the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case, or other similar article or receptacle sold for use in agricultural, livestock or dairy production.
- c. No vehicle subject to registration, as defined in Iowa Code subsection 423.1(7), implement customarily drawn or attached to a vehicle, auxiliary attachment, or any replacement part for a vehicle, implement, or auxiliary attachment is eligible for the exemption or refund allowed under this rule.

**18.44(2) Definitions and characterizations.** For the purposes of this rule, the following definitions apply.

a. Production of agricultural products means the same as the term “agricultural production” which is defined in 701—subrule 17.9(3), paragraph “a,” to mean a farming operation undertaken for profit by raising crops or livestock. Production of agricultural products begins with the cultivation of land previously cleared for planting of crops or with the purchase or breeding of livestock or domesticated fowl. Not included within the meaning of the phrase are the clearing or preparation of previously uncultivated land, the creation of farm ponds or the erection of machine sheds, confinement facilities, storage bins or other farm buildings. See *Trullinger v. Fremont County*, 223 Iowa 677, 273 N.W. 124 (1937). Machinery and equipment used for these purposes would be used for activities which are preparatory to but not a part of the production of agricultural products. The production of agricultural products ceases when an agricultural product has been transported to the point where it will be sold by the farmer or processed.

EXAMPLE. Farmer Brown uses a tractor and wagon to haul harvested corn from a field to a grain dryer located on the farm. After the corn is dried, the same tractor and wagon are used to move the grain to a storage bin, also located on the farm. Later the same tractor and wagon are used to deliver the corn from the farm to the local elevator where it is sold. After Farmer Brown deposits the corn there, the local elevator uses its own tractor and wagon to move the corn to a place of relatively permanent storage. Farmer Brown has used the tractor and wagon in the production of agricultural products and the refund or exemption would apply. The elevator has not used its tractor and wagon in such production; refund or exemption would not be lawful.

b. Farm machinery and equipment means machinery and equipment specifically designed for use in the production of agricultural products or equipment and machinery not specifically designed for this use but which are directly and primarily used in the production of agricultural products.

EXAMPLE. Farmer Jones raises livestock and the farming operation requires that fences be built to confine the livestock. Farmer Jones purchases a posthole digger that is customarily attached to a tractor and uses the digger to construct the fences used to confine the livestock. The posthole digger is not specifically designed for use in the production of agricultural products but would be directly and primarily used in the production of agricultural products. Therefore, the exemption or refund applies.

c. Self-propelled implement has the same meaning as in 701—subrule 17.9(5), paragraph “c,” where the term is defined to mean an implement which is capable of movement from one place to another under its own power. The term self-propelled implement includes but is not limited to the following items: skidloaders and tractors; and the following machinery if capable of movement under its own power: combines, corn pickers, fertilizer spreaders, hay conditioners/windrowers, sprayers, and bean buggies.

*d.* Implements customarily drawn or attached to self-propelled implements. The following is a nonexclusive, representative list of implements which are customarily drawn or attached to self-propelled implements: Augers, balers, blowers, combines, conveyers, cultivators, disks, drags, dryers (portable), farm wagons, feeder wagons, fertilizer spreaders, front- and rear-end loaders, harrows, hay loaders, mowers and rakes, husking machines, manure spreaders, planters, plows, rotary blade mowers, rotary hoes, sprayers and tanks, and tillage equipment.

*e.* Direct use in agricultural production. In determining whether farm machinery, equipment or any grain dryer is directly used in agricultural production, the fact that particular machinery or equipment is essential to the production of agricultural products because its use is required either by law or practical necessity does not, of itself, mean that the machinery or equipment is directly used in the production of agricultural products. Machinery or equipment coming into actual physical contact with the soil or crops during the operations of planting, cultivating, harvesting, and soil preparation will be presumed to be machinery or equipment used in agricultural production.

*f.* Grain dryer. The term grain dryer includes the heater and the blower necessary to force the warmed air into a grain storage bin. It does not include equipment used in grain storage or movement such as augers and spreaders or any other equipment that is not a grain dryer. Equipment other than a grain dryer which is used in grain drying may be exempt or subject to refund if the equipment is a self-propelled implement or customarily drawn or attached to a self-propelled implement.

*g.* Replacement parts, differing meanings of the term for the period ending June 30, 1988, and for the period beginning July 1, 1988.

(1) For the period beginning July 1, 1985, and ending June 30, 1988, a replacement part is refundable or exempt only if its cost is depreciable for state and federal income tax purposes. Replacement parts which are depreciable for state and federal income tax purposes include only those replacement parts which either materially add to the value of machinery or equipment or appreciably prolong its life. Replacement parts which only keep the machinery or equipment in its ordinarily efficient operating condition are not eligible for exemption or refund. Included within the meaning of replacement parts is any part the cost of which is depreciable for state and federal income tax purposes but which may also be deducted as a current expense. So long as the cost is depreciable the sale or lease of the replacement part is eligible for refund or exemption from tax. However, the person claiming the refund or exemption must show that the replacement part which was deducted as an expense could have been depreciated under state and federal income tax law.

(2) On and after July 1, 1988, the sale or lease of a replacement part is exempt from tax if the replacement part is essential to any repair or reconstruction necessary to farm machinery or equipment's exempt use in the production of agricultural products. The term "replacement part" does not include attachments and accessories which are not essential to the operation of the farm machinery or equipment. Nonexclusive examples of attachments or accessories are: cigarette lighters, radios, and add-on air-conditioning units.

**18.44(3)** *Taxable and nontaxable transactions.* The following are nonexclusive examples of sales and leases of farm machinery and equipment which are or are not subject to exemption and refund.

*a.* A lessor's purchase of farm machinery and equipment is not subject to tax, or is taxable subject to refund, if the machinery or equipment is leased to a lessee who uses it directly and primarily in the production of agricultural products and if the lessee's use of the machinery or equipment is otherwise exempt or subject to refund. To claim exemption from tax or a refund of tax paid, the lessor need not make exempt use of the machinery or equipment so long as the lessee does.

*b.* To claim refund or exemption, the owner or lessee of farm machinery or equipment need not be a farmer so long as the machinery and equipment is directly and primarily used in the production of agricultural products, and the owner or lessee and the equipment or machinery meet the other requirements of this rule. For example, a person who purchases an airplane designed for use in agricultural aerial spraying and so used after purchase is entitled to the benefits of this rule even though that person is not the owner or occupant of the land where the airplane is used.

c. The sale or lease, within Iowa, of any farm machinery, equipment, or replacement part for direct and primary use in agricultural production outside of Iowa is a transaction eligible for refund or exemption if those transactions are otherwise qualified under this rule.

**18.44(4) Auxiliary attachments.** The following is a list (not inclusive) of auxiliary attachments described in 18.44(1)“b”(4), the sale or first use in Iowa which is exempt from tax on and after July 1, 1995: auxiliary hydraulic valves, cabs, coil tine harrows, corn head pickup reels, dry till shanks, dual tires, extension shanks, fenders, fertilizer attachments and openers, fold kits, grain bin extensions, herbicide and insecticide attachments, kit wraps, no-till coulters, quick couplers, rear wheel assists, rock boxes, rollover protection systems, rotary shields, stalk choppers, step extensions, trash whips, upperbeaters, silage bags, and weights.

**18.44(5) and 18.44(6)** Rescinded IAB 9/7/88, effective 10/12/88.

This rule is intended to implement Iowa Code subsections 422.43(3) and 422.45(26), Iowa Code chapter 422, Division IV, and Iowa Code section 422.45 as amended by 1996 Iowa Acts, chapter 1145.

**701—18.45(422,423) Sale or rental of computers, industrial machinery and equipment; refund of and exemption from tax paid for periods prior to July 1, 1997.** The sale or rental of computers, industrial machinery and equipment, including pollution control equipment, used in manufacturing, in research and development, or in the processing or storage of data or information by an insurance company, financial institution, or commercial enterprise is, under certain circumstances, exempt from tax and, under other circumstances, is subject to refund of sales or use tax paid. The sale or rental of machinery, equipment, or computers directly and primarily used in the recycling or reprocessing of waste products is also exempt from tax; see subrule 18.45(8). For purposes of the organization of this rule, items that may be exempt or subject to refund of tax are referred to as specified property unless the context of the rule indicates otherwise. See subrule 18.45(1) for definition of what constitutes specified property. See rule 18.58(422,423) for the manner in which the sale or rental of machinery, equipment, and computers to manufacturers and the sale or rental of computers to commercial enterprises are treated on and after July 1, 1997.

**18.45(1) Definitions.** The following words are defined for the purposes of this rule in the manner set out below.

“*Commercial enterprise*” includes businesses and manufacturers conducted for profit and includes centers for data processing services to insurance companies, financial institutions, businesses, and manufacturers, but excludes professions and occupations and nonprofit organizations. A hospital that is a not-for-profit organization would not be a “commercial enterprise.” The term “professions” means a vocation or employment requiring specialized knowledge and often long and intensive academic preparation. The term “occupations” means the principal business of an individual. Included within the meaning of “occupations” is the business of farming. A professional corporation which carries on any business which is a “profession” or “occupation” is not a commercial enterprise.

“*Computer*” means stored program processing equipment and all devices fastened to it by means of signal cables or any communication medium that serves the function of a signal cable. Nonexclusive examples of devices fastened by a signal cable or other communication medium are: terminals, printers, display units, card readers, tape readers, document sorters, optical readers, and card or tape punchers. Excluded from the definition of “computer” is point-of-sale equipment. For a characterization of “point-of-sale equipment” see 701—subrule 71.1(7).

Also included within the meaning of the word “computer” is any software consisting of an operating system or executive program. Such software coordinates, supervises, or monitors the basic operating procedures of a computer. An operating system or executive program is exempt from sales tax only if purchased as part of the sale of the computer for which it operates. An operating system or executive program priced separately or sold at a later time is subject to the provisions of rule 18.34(422,423). Excluded from the meaning of the word “computer” is any software consisting of an application program. For purposes of this subrule, “operating system or executive program” means a computer program which is fundamental and necessary to the functioning of a computer. The operating system or executive program software controls the operation of a computer by managing the allocation of

all system resources, including the central processing unit, main and secondary storage, input/output devices, and the processing of programs. This is in contrast to application software which is a collection of one or more programs used to develop and implement the specific applications which the computer is to perform, and which calls upon the services of the operating system or executive program.

*"Directly used."* Property is "directly used" only if it is used to initiate, sustain, or terminate the transformation of any activity. In determining whether any property is "directly used," consideration should be given to the following factors:

1. The physical proximity of the property in question to the activity in which it is used;
2. The proximity of the time of use of the property in question to the time of use of other property used before and after it in the activity involved; and
3. The active causal relationship between the use of the property in question and the activity involved. The fact that a particular piece of property may be essential to the conduct of the activity because its use is required either by law or practical necessity does not, of itself, mean that the property is directly used.

*"Financial institution"* is a bank incorporated under Iowa Code chapter 524 or federal law; a savings and loan association incorporated under Iowa Code chapter 534 or federal law; a credit union organized under Iowa Code chapter 533 or federal law; or any corporation licensed as an industrial loan company under Iowa Code chapter 536A. Excluded from the meaning of the term are loan brokers governed by Iowa Code chapter 535C and production credit associations.

*"Industrial machinery and equipment"* means machinery and equipment used by a manufacturer in a manufacturing establishment. Machinery is any mechanical, electrical or electronic device designed and used to perform some function and to produce a certain effect or result. The word includes not only the basic unit of the machinery but also any adjunct or attachment necessary for the basic unit to accomplish its intended function. The word also includes all devices used or required to control, regulate or operate a piece of machinery, provided such devices are directly connected with or are an integral part of the machinery and are used primarily for control, regulation or operation of machinery. Jigs, dies, tools, and other devices necessary to the operation of or used in conjunction with the operation of what would be ordinarily thought of as machinery are also considered to be "machinery." See *Deere Manufacturing Co. v. Zeiner*, 247 Iowa 1264 78 N.W.2d 527 (1956). Machinery does not include buildings designed specifically to house or support machinery. Equipment is any tangible personal property used in an operation or activity. Nonexclusive examples of equipment are: tables on which property is assembled on an assembly line and chairs used by assembly line workers.

*"Insurance company"* means an insurer organized or operating under Iowa Code chapter 508, 514, 515, 518, 519, or 520 or authorized to do business in Iowa as an insurer. An insurance company must have 50 or more persons employed in Iowa, excluding licensed insurance agents. Effective April 8, 1996, an insurance company means an insurer organized or operating under Iowa Code chapter 508, 514, 515, 518, 518A, 519, or 520 or authorized to do business in this state as an insurer or licensed insurance agent under Iowa Code chapter 522. Excluded from the definition of "insurance company" are fraternal and beneficial societies governed by Iowa Code chapter 512 and health maintenance organizations governed by Iowa Code chapter 514B. This list of exclusions is not intended to be exclusive.

*"Manufacturer"* means any person, firm, or corporation who purchases, receives, or holds personal property for the purpose of adding to its value by any process of manufacturing, refining, purifying, combining of different materials, or by packing of meats with an intent to sell at a gain or profit. Those who are in the business of printing, newspaper publication, bookbinding, lumber milling, and production of drugs and agricultural supplies are illustrative, nonexclusive examples of manufacturers. Construction contracting; quarrying; remanufacture or rebuilding of tangible personal property (such as automobile engines); provision of health care; farming; transportation for hire; mining; and the activities of restaurateurs, hospitals, and medical doctors are illustrative, nonexclusive examples of businesses which are not manufacturers. See *Associated General Contractors of Iowa v. State Tax Commission*, 255 Iowa 673, 123 N.W.2d 922 (1963) and *River Products Co. v. Board of Review of Washington County*, 332 N.W.2d 116 (Iowa Ct. App. 1982).

*“Pollution control equipment”* means any disposal system or apparatus used or placed in operation primarily for the purpose of reducing, controlling or eliminating air or water pollution. The term does not include any apparatus used to eliminate “noise pollution.” Liquid, solid, and gaseous wastes are included within the meaning of the word “pollution.”

*“Processing”* means an operation or series of operations whereby tangible personal property is subjected to some special treatment by artificial or natural means which changes its form, context, or condition, and results in marketable tangible personal property. See rule 18.29(422,423).

*“Processing or storage of data or information.”* Not only a computer, but machinery or equipment may be used in the processing or storage of data or information. All computers store and process information. However, only if the “final output” for a user or consumer is stored or processed data will the computer be subject to refund or exemption of tax.

*“Recycling”* means any process by which waste, or materials which would otherwise become waste, are collected, separated, or processed and revised or returned for use in the form of raw materials or products. The term includes, but is not limited to, the composting of yard waste which has been previously separated from other waste. “Recycling” does not include any form of energy recovery.

*“Replacement parts.”* Replacement parts which are depreciable for state and federal income tax purposes include only those replacement parts which either materially add to the value of industrial machinery, equipment, or computers or appreciably prolong their lives. Replacement parts which only keep machinery, equipment, or computers in their ordinarily efficient operating condition are not eligible for exemption. Included within the meaning of replacement parts is any part the cost of which is depreciable for state and federal income tax purposes but which may also be deducted as a current expense. So long as the cost is depreciable the sale or lease of the replacement part is eligible for exemption from tax. However, the person claiming the exemption must show that the replacement part which was deducted as an expense could have been depreciated under state and federal income tax law.

*“Research and development”* means experimental or laboratory activity which has as its ultimate goal the development of new products, processes of manufacturing, refining, purifying, combining of different materials, or meat packing. The ultimate goal of research and development must be that of adding value to products. The term “research and development” does not include testing or inspection for quality control purposes, efficiency surveys, management studies, consumer surveys, advertising, promotions, or research in connection with literary, historical, or similar projects. Machinery, equipment, and computers are used “directly” in research and development only if they are used in actual experimental or laboratory activity that qualifies as research and development under this subrule.

*“Specified property”* means property that is a computer or industrial machinery and equipment including pollution control equipment and depreciable replacement parts for that property.

**18.45(2) Requirements.** The sale or rental of specified property is exempt from tax if:

*a.* The property is real property within the scope of Iowa Code section 427A.1(1) “e” or “j.” For sales occurring after January 1, 1994, the property is not required to be subject to taxation as real property (however, see subrules 18.45(4) and 18.45(8)); and

*b.* The property is directly and primarily used in one of the following:

1. By a manufacturer in processing tangible personal property; or

2. In research and development of new products or processes of manufacturing, refining, purifying, combining of different materials or packing of meats to be used for the purposes of adding value to products; or

3. In processing or storage of data or information by an insurance company, financial institution, or commercial enterprise.

*c.* To qualify for refund or exemption, a computer may be taxable as either commercial or industrial real estate. Machinery and equipment must be taxable as industrial real estate only to be similarly qualified. Research and development machinery and equipment that is not taxable as industrial real estate does not qualify for refund or exemption. See 701—subrules 71.1(5) and 71.1(6) for characterizations of “commercial” and “industrial” real estate. However, see subrule 18.45(4) for an exception to the requirement that certain property be taxable as real property.

*d.* The following are examples of machinery which is not directly used in manufacturing:

1. Machinery used exclusively for the efficient use of other machinery. Examples are: air cooling, air conditioning, and exhaust systems.
2. Machinery used in support operations, such as a machine shop, in which production machinery is assembled, maintained or repaired.
3. Machinery used by administrative, accounting, and personnel departments.
4. Machinery used by plant security, fire prevention, first aid, and hospital stations.
5. Machinery used in plant cleaning, disposal of scrap and waste, plant communications, lighting, safety, or heating.

*e.* The following is an example of property directly used in research and development: Frontier Hybrid, Inc. maintains a research and development laboratory for use in developing a corn plant which is a perennial. It purchases the following items for use in its research and development laboratory: a computer which will process data relating to the genetic structure of the various corn plants which Frontier Hybrid is testing, an electron microscope for examining the structure of corn plant genes, a “steam cleaner” for cleaning rugs in the laboratory offices, and a typewriter for use by the laboratory director’s secretary. The computer and the microscope are “directly” used in the research in which the laboratory is engaged; the steam cleaner and the typewriter only indirectly used. Therefore, purchase of the computer and microscope would be exempt from tax; purchase of the steam cleaner and typewriter would be subject to tax.

*f.* The following is an example of property used in processing or storage of information or data: A health insurance company has three computers. Computer A is used to monitor the temperature within the insurance company’s building. The computer transmits messages to the building’s heating and cooling systems telling them when to raise or lower the level of heating or air conditioning as needed. Computer B is used to store patient records and will recall those records on demand. Computer C is used to tabulate statistics regarding the amount of premiums paid in and the amount of benefit paid out for various classes of insured. The “final output” of Computer A is neither stored nor processed information. The final output of Computer B is stored information. The final output of Computer C is processed information. The sale, lease, or use of Computers B and C would qualify for exemption or refund.

*g.* The following is an example of property not used in manufacturing: A manufacturing plant located in Warren County which manufactures widgets fabricates its own patterns used in manufacturing the widgets on a metal press machine in its machine shop located in Story County. The machine shop does not sell the patterns and the metal press machine is used for no other purpose than to fabricate the patterns. The metal press machine is not used in manufacturing because there is no intent to sell the patterns used by the machine shop at a gain or profit.

**18.45(3) Exceptions.** The following specified property is not exempt:

*a.* Property assessed by the department of revenue pursuant to Iowa Code chapters 428, 433, 434 and 436 to 438, inclusive. For electric, gas, water, and other companies assessed under Iowa Code chapter 428, only property owned by the company is assessed by the department. For railroad, telephone, pipeline, and electric transmission lines companies, property leased to as well as owned by the company is assessed by the department. See 701—Chapters 71 and 77.

*b.* Hand tools.

*c.* Point-of-sale equipment. See 701—subrule 71.1(7).

**18.45(4) Inclusions.** Property exempt from taxation for property tax purposes under the provisions of Iowa Code chapters 404 and 427B relating to urban revitalization property and industrial machinery receiving partial exemption by ordinance is also eligible for exemption from sales and use taxes even though the property is not subject to taxation as real property. Urban revitalization property and industrial machinery receiving partial exemption by ordinance are discussed in rules 701—80.8(404) and 80.6(427B), respectively. This property must meet the other requirements in subrule 18.45(2) in order to be exempt from sales and use taxes.

**18.45(5) Lessor purchases of specified property.** The analysis contained in rule 18.44(422,423) regarding lessor purchases of farm machinery and equipment is applicable to explain that same problem regarding specified property. See subrule 18.44(3) for analysis.

**18.45(6) Rights of refund and exemption.** Rescinded IAB 10/13/93, effective 11/17/93.

**18.45(7) *Designing or installing new industrial machinery or equipment.*** On and after July 1, 1985, the gross receipts from the services of designing or installing new industrial machinery or equipment shall be exempt from tax. The enumerated services of electrical or electronic installation are included in this exemption. To qualify for the exemption, the sale or rental of the machinery or equipment must be subject to refund or exemption under this rule. In addition, the machinery or equipment must be “new.” For purposes of this subrule, “new” means never having been used or consumed by anyone. The exemption is not applicable to reconstructed, rebuilt or repaired or previously owned machinery or equipment. The exemption is applicable to new machinery and equipment designed or installed for rental as well as for sale. The gross receipts from design or installation must be separately identified, charged separately, and reasonable in amount for the exemption to apply. A “computer” is not considered to be machinery or equipment, and its installation or design is not eligible for this exemption.

**18.45(8) *Property used in recycling or reprocessing of waste products.*** On and after July 1, 1989, the gross receipts from the sale or rental of machinery, equipment, or computers directly and primarily used in the recycling or reprocessing of waste products shall be exempt from tax. Machinery or equipment used in the recycling or reprocessing of waste products includes, but is not limited to, compactors, balers, crushers, grinders, cutters, or shears directly and primarily used for this purpose. The sale of an endloader, forklift, truck, or other moving device is exempt from tax if the device is directly and primarily used in the movement of property which is an integral part of recycling or reprocessing. See 18.45(8) “c.” The sale of a bin for storage ordinarily would not be exempt from tax, storage without more not being a part of recycling or reprocessing. Certain limits for exemption placed upon industrial machinery and equipment are not applicable to machinery and equipment used in recycling or reprocessing.

For example, machinery, equipment or a computer need not meet the requirements of 18.45(2) “a” concerning specified property being real property for the exemption to apply. Furthermore, the exemption will apply even if the machinery, equipment or computer is purchased by a person other than an insurance company, financial institution or commercial enterprise. For instance, a person engaged in a profession or occupation could purchase property for direct and primary use in recycling or reprocessing of waste products and the exemption would apply.

*a.* By way of nonexclusive examples, recycling or reprocessing can begin when waste or material which would otherwise become waste is collected or separated. A vehicle used directly and primarily for collecting waste which will be recycled or reprocessed could be a vehicle used for an exempt purpose under this rule. Thus, the purchaser of a garbage truck could claim this exemption if the truck were directly and primarily used in recycling and not, for instance, in hauling garbage to a landfill. Machinery or equipment used to segregate waste from material to be recycled or reprocessed or used to separate various forms of materials which will be reprocessed (e.g., glass and aluminum) can also be used at the beginning of recycling or reprocessing.

*b.* Machinery and equipment directly and primarily used in recycling or reprocessing. See subrule 18.45(1) for the definition of “directly used” which is applicable to this subrule. The examples of machinery not directly used in manufacturing set out in 18.45(2) “d” should be studied for guidance in determining whether similar machinery is or is not used in recycling or reprocessing; e.g., machinery used in plant security (see 18.45(2) “d”<sup>4</sup>) is not machinery directly used in recycling or reprocessing.

*c.* Integral use in recycling or reprocessing. Ordinarily, any operation or series of operations which does not transform waste or material which would otherwise become waste into new raw materials or products would not be a part of recycling or reprocessing. However, activities which do not do this, but are an “integral part” of recycling or reprocessing, are themselves recycling or reprocessing. For example, an endless belt which moves aluminum cans from a machine where they are shredded to a machine where the shredded aluminum is crushed into blocks would be an endless belt used in recycling or reprocessing and the exemption applies. See subrule 18.29(5) for a discussion of when an activity is an integral part of “processing.” Some of that discussion is applicable to this subrule.

*d.* The end of recycling or reprocessing. Recycling or reprocessing ends when waste or a material which would otherwise become waste is in the form of raw material in which it will be used in manufacturing or in the form of a product which will be sold for use other than as a raw material in manufacturing. For instance, a corporation purchases a machine which grinds logs, stumps, pallets, and

crates and other waste wood into wood chips. After grinding, the wood chips are sold and transported to purchasers to various sites where the chips are dumped on and spread out over the ground for use in erosion control. The machine which grinds the wood chips is a machine used in recycling. The truck which transports the wood chips from the machine to the sites is not used in reprocessing because, at the time the chips are placed in the truck, they are in the form in which they will be sold for use other than as a raw material in manufacturing.

This rule is intended to implement Iowa Code section 422.45(26), Iowa Code section 422.45(27) as amended by 1996 Iowa Acts, chapter 1049, and Iowa Code section 422.45(29).

**701—18.46(422,423) Automotive fluids.** The gross receipts from the sales of certain automotive fluids are exempt from tax. To be considered exempt, the sale must possess the following characteristics: (1) the sale must be to a retailer who will install the automotive fluid in or apply the automotive fluid to a motor vehicle; and (2) the installation or application must be done while the retailer is providing a taxable enumerated service (e.g., automobile lubrication); or (3) the automotive fluid must be installed in or applied to a motor vehicle which the retailer intends to sell and the sale of which will be subject to Iowa use tax.

Specific but nonexclusive examples of “automotive fluids” are motor oil and other automobile lubricants, hydraulic, brake, and transmission fluids, sealants, undercoatings, antifreeze, and gasoline additives.

This rule is intended to implement Iowa Code section 422.45(33).

**701—18.47(422,423) Maintenance or repair of fabric or clothing.**

**18.47(1)** As of July 1, 1987, sales of chemicals, solvents, sorbents, or reagents consumed in the maintenance or repair of fabric or clothing are exempt from tax. See 701—subrule 17.14(1) for definitions of the terms “chemical, solvent, sorbent or reagent.” This subrule’s exemption is mainly applicable to dry-cleaning and laundry establishments; however, it is also applicable to soap or any chemical or solvent used to clean carpeting. The department presumes that a substance is “directly used” in the maintenance or repair of fabric or clothing if the substance comes in contact with the fabric or clothing during the maintenance or repair process. Substances which do not come into direct contact with fabric or clothing may, under appropriate circumstances, be directly used in the maintenance or repair of the fabric or clothing but direct use will not be presumed.

The following are examples of substances directly used and consumed in the maintenance or repair of fabric or clothing: perchloroethylene “perch” or petroleum solvents used in dry-cleaning machines and coming in direct contact with the clothing being dry-cleaned. Substances used to clean or filter the “perch” or petroleum solvents would also be exempt from tax, even though these substances do not come in direct contact with the clothing being cleaned. The sale of soap or detergents especially made for mixing with “perch” or petroleum solvents is exempt. The sale of stain removers to dry cleaners is exempt from tax.

A commercial laundry’s purchase of detergents, bleaches, and fabric softeners is exempt from tax. A commercial laundry’s purchase of water, which is a solvent, is also exempt from tax if purchased for use in the cleaning of clothing.

The purchase of starch by laundries and “sizing” by dry cleaners is not exempt from tax.

**18.47(2)** Also, on and after July 1, 1987, the sale of property which is a container, label, or similar article or receptacle for transfer in association with the maintenance or repair of fabric or clothing is exempt from tax. In general, the sale of any article which protects dry-cleaned or laundered clothing from dirt or helps the dry-cleaned or laundered clothing to maintain its proper shape or form in the same fashion as a container does would be exempt from tax under this subrule. By way of nonexclusive example, the sale of plastic garment bags, which protect clothing from dirt, is exempt from tax. The sale of “shirt boards” and garment hangers, both of which help clothing to maintain its proper shape, would also be exempt.

A container, label, or similar article’s sale is exempt from tax only if the item is transferred to the customer of a commercial laundry, dry cleaner, or other retailer. Thus, “bundle bags” and “meese carts,”

used to transfer or transport clothing within a dry-cleaning establishment, are not subject to the exemption because these bags and carts remain with the dry cleaner and are not transferred to a customer.

Concerning labels, the sale of which would be exempt from tax, these labels must be affixed to the dry-cleaned or laundered clothing and transferred to the customer of the dry-cleaning or laundering establishment. By way of nonexclusive example, the sale to dry cleaners, of “special attention,” “invoice” and “sorry” tags would be exempt from tax.

The sale of safety pins and other types of clips used to hang skirts and other garments from hangers would not be exempt from tax. These items do not sufficiently resemble containers or labels to the extent that their sale is exempt from tax.

This rule is intended to implement Division IV of Iowa Code chapter 422.

**701—18.48(422,423) Sale or rental of farm machinery, equipment, replacement parts, and repairs used in livestock, dairy, or plant production.** Sales or rental of farm machinery and equipment used in livestock or dairy production and replacement parts which occur on or after July 1, 1988, are exempt from sales and use tax. On and after July 1, 1995, machinery, equipment, and replacement parts used in the production of flowering, ornamental, or vegetable plants are exempt from tax. See rule 701—18.57(422,423).

**18.48(1) Definitions and characterizations.** For the purposes of this rule, the following definitions and characterizations of words apply.

a. “Machinery” means major mechanical machines or major components thereof which contribute directly and primarily to the livestock or dairy production process. Usually, a machine is a large object with moving parts which performs work by the expenditure of energy, either mechanical (e.g., gasoline or kerosene) or electrical.

b. “Equipment” is tangible personal property (other than a machine) directly and primarily used in livestock or dairy production. It may be characterized as property which performs a specialized function which, of itself, has no moving parts or if it does possess moving parts, its source of power is external to it. The following examples attempt to differentiate between machinery and equipment:

EXAMPLE A. An electric pump is used to pump milk into a bulk milk tank. The electric pump is machinery; the bulk milk tank is equipment.

EXAMPLE B. An auger places feed into a cattle feeder. If not “real property” (see 18.48(1) “c”) the auger is a piece of machinery; the cattle feeder is a piece of equipment.

c. Property used in livestock or dairy production which is neither “equipment” nor “machinery.”

(1) Real property. The ground or the earth is not machinery or equipment. A building is not machinery or equipment, *Mid-American Growers, Inc. v. Dept. of Revenue*, 493 N.E.2d 1097 (Ill. App. Ct. 1986). Therefore, tangible personal property which is sold for incorporation into the ground or a building in such a manner that it will become a part of the ground or the building is taxable. Generally, property incorporated into the ground or a building has become a part of the ground or the building if removal of the property from the ground or building will substantially damage the property, ground, or building or substantially diminish the value of the property, ground, or building. Fence posts embedded in concrete and electrical wiring, light fixtures, fuse boxes, and switches are examples of property sold for incorporation into the ground or a building, respectively. The property referred to in 18.48(1) “c”(1) can be identified by applying the following test: Assume that the property is being sold to a contractor rather than a person engaged in livestock or dairy production. If sold to a contractor, would the retailer be required to consider the property “building material” and charge the contractor sales tax upon the purchase of this building material. If this is the case, sale of the property is not exempt from Iowa tax law. Iowa department of revenue rule 701—19.3(422,423) contains a characterization of “building material” and a list of specific examples of building material.

(2) “Supplies” are neither machinery nor equipment. Tangible personal property is part of farm supplies if it is used up or destroyed by virtue of its use in livestock or dairy production or, because of its nature, can only be used once in livestock or dairy production. A light bulb is an example of a farm supply which is not machinery or equipment. The sale of some farm supplies is exempt from tax. See

701—subrule 17.9(3). See List B in subrule 18.48(7) for examples of farm supplies which could be mistaken for equipment and are not exempt from tax on other grounds.

*d.* “Hand tools” are tools which can be held in the hand or hands and which are powered by human effort. Hand tools specifically designed for use in livestock or dairy production are exempt from tax as “equipment.” Mechanical devices that are held in the hand and driven by electricity or some source other than human muscle power are, if otherwise qualified, exempt from tax as “farm machinery.” See subrule 18.48(7), List C, for examples of “hand tools” exempt and not exempt from tax.

*e.* Directly used in livestock or dairy production. To determine if machinery or equipment is “directly” used in livestock or dairy production, one must first ensure that the machinery or equipment is used during livestock or dairy production and not before that process has begun or after it has ended. Subrule 18.48(1), paragraph “g,” describes when livestock or dairy production begins and ends. If the machinery or equipment is used in livestock or dairy production, to be “directly” so used, that use must constitute an integral and essential part of production as distinguished from a use in production which is incidental, merely convenient to or remote from production. The fact that machinery or equipment is essential or necessary to livestock or dairy production does not mean that it is also “directly” used in production. Machinery or equipment may be necessary to livestock or dairy production but so remote from it that it is not directly used in that production.

(1) In determining whether machinery or equipment is used directly, consideration should be given to the following factors:

1. The physical proximity of the machinery or equipment to other machinery or equipment whose direct use is unarguable. The closer the machinery or equipment whose direct use is questioned is to the machinery or equipment whose direct use is not questioned, the more likely it is that the former is directly used in livestock or dairy production.

2. The proximity in time of the use of machinery or equipment whose direct use is questionable to the use of machinery whose direct use is not questioned. The closer in time the use, the more likely that the questioned machinery or equipment’s use is direct rather than remote.

3. The active causal relationship between the use of the machinery or equipment in question and livestock or dairy production. The fewer intervening causes between the use of the machinery or equipment and the production of the product, the more likely it is that the machinery or equipment is directly used in production.

(2) The following are examples of machinery and equipment directly used in livestock or dairy production:

1. Machinery and equipment used to transport or limit the movement of livestock and dairy animals (e.g., electric fence equipment, head gates, and loading chutes).

2. Machinery and equipment used in the conception, birth, feeding, and watering of livestock or dairy animals (e.g., artificial insemination equipment, portable farrowing pens, feed carts, and automatic watering equipment).

3. Machinery and equipment used to maintain healthful or sanitary conditions in the immediate area where livestock are kept (e.g., manure gutter cleaners, automatic cattle oilers, fans, and heaters if not real property).

4. Machinery or equipment used to test or inspect livestock or dairy animals during production.

(3) The following are nonexclusive examples of machinery or equipment which would not be directly used in livestock or dairy production.

1. Machinery or equipment used to assemble, maintain, or repair other machinery or equipment directly used in livestock or dairy production (e.g., welders, paint sprayers, and lubricators).

2. Machinery used in farm management, administration, advertising, or selling (e.g., a recordkeeping computer, calculating machine, office safe, telephone, books, and farm magazines).

3. Machinery or equipment used in the exhibit of livestock or dairy animals (e.g., blankets, halters, prods, leads, and harnesses).

4. Machinery or equipment used in safety or fire prevention, even though the machinery or equipment is required by law.

5. Machinery or equipment for employee or personal use. Machinery or equipment used for the personal comfort, convenience, or use by a farmer, the farmer's family or employees, or persons associated with the farmer are not exempt from tax. Examples of such machinery and equipment include the following: beds, mattresses, blankets, tableware, stoves, refrigerators, and other equipment used in conjunction with the operation of a farm home or of a migrant labor camp, or other facilities for farm employees.

6. Machinery and equipment used for heating, cooling, ventilation, and illumination of farm buildings generally rather than specifically in the immediate area where livestock are kept.

7. Vehicles subject to registration.

f. "Primarily" used in livestock or dairy production. Machinery or equipment is "primarily used in livestock or dairy production" if of the total time that unit of machinery or equipment is used, more than 50 percent of the time is in livestock or dairy production. If a unit of machinery or equipment is used more than 50 percent of the time for production and the balance of time for other business purposes, the exemption applies. If a unit of equipment is used 50 percent or more of the time for business purposes other than livestock or dairy production, the exemption does not apply. Any unit of machinery or equipment used more than 50 percent of the time directly in livestock or dairy production is subject to the exemption.

g. Beginning and end of livestock or dairy production. Livestock or dairy production begins with the purchase or breeding of livestock or dairy animals. Livestock and dairy production ceases when an animal or the product of an animal's body (e.g., wool or milk) has been transported to the point where it will be sold by the farmer or processed.

h. Farm machinery and equipment means machinery and equipment specifically designed for use in livestock and dairy production or equipment and machinery not specifically designed for this use but which are directly and primarily used in livestock or dairy production except for common or ordinary hand tools. See 18.48(1) "d" for a definition of "hand tools."

EXAMPLE. Farmer Jones raises livestock and fans must be used to cool the animals. Farmer Jones buys fans designed for use in a residence which he uses directly and solely to cool the livestock. The exemption applies.

i. "Self-propelled implement" has the same meaning as in 701—subrule 17.9(5), paragraph "c" where the term is defined to mean an implement which is capable of movement from one place to another under its own power. The term self-propelled implement includes but is not limited to the following items: skidloaders and tractors; and the following machinery if capable of movement under its own power: combines, corn pickers, fertilizer spreaders, hay conditioners/windrowers, sprayers, and bean buggies.

j. Implements customarily drawn or attached to self-propelled implements. The following is a nonexclusive, representative list of implements which are customarily drawn or attached to self-propelled implements: augers, balers, blowers, combines, conveyers, cultivators, disks, drags, dryers (portable), farm wagons, feeder wagons, fertilizer spreaders, front- and rear-end loaders, harrows, hay loaders, mowers and rakes, husking machines, manure spreaders, planters, plows, posthole diggers, rotary blade mowers, rotary hoes, sprayers and tanks, and tillage equipment.

k. The term "grain dryer" includes the heater and the blower necessary to force the warmed air into a grain storage bin. It does not include equipment used in grain storage or movement such as augers and spreaders or any other equipment that is not a grain dryer. Equipment other than a grain dryer which is used in grain drying may be exempt or subject to refund if the equipment is a self-propelled implement or customarily drawn or attached to a self-propelled implement.

l. The term "replacement parts essential to any repair or reconstruction necessary to farm machinery or equipment's exempt use in the production of agricultural products" does not include attachments and accessories not essential to the operation of the machinery or equipment itself (except when sold as part of the assembled unit) such as cigarette lighters, radios, canopies, air conditioning units, cabs, deluxe seats, and tools or utility boxes.

**18.48(2)** *Right of refund for farm machinery and equipment used in livestock or dairy production, basic requirements.* Rescinded IAB 10/13/93, effective 11/17/93.

**18.48(3)** *Treatment of replacement parts.* Rescinded IAB 10/13/93, effective 11/17/93.

**18.48(4)** *Packing material used in agricultural, livestock, or dairy production.* For sales occurring on or after July 1, 1996, the gross receipts from the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case, or other similar article or receptacle sold for use in agricultural, livestock, or dairy production are not subject to sales tax. This exemption also applies to producers of ornamental, flowering, or vegetable plants in commercial greenhouses or other places which sell such items in the ordinary course of business since that activity is considered to be agricultural.

**18.48(5)** Rescinded IAB 11/20/96, effective 12/25/96.

**18.48(6)** *Auxiliary attachments exemption.* On and after July 1, 1995, sales of auxiliary attachments which improve the performance, safety, operation, or efficiency of machinery or equipment are exempt from tax. Sales of replacement parts for these auxiliary attachments are also exempt on and after that date.

**18.48(7)** *Lists.* Lists (representative but not all-inclusive) of tangible personal property for which sales or use tax paid is or is not refundable.

LIST A. Property Used in Livestock and Dairy  
Production Which is Usually Real Property. See  
18.48(1)“c”(1). Its sale is usually taxable.

barn ventilators*	livestock feeders*
conveyers*	silos
farrowing crates*	specialized flooring*
fence posts	sprinklers
fencing wire	stanchions
furnaces*	watering tanks*
gestation stalls*	ventilators*

\*These items also appear in List D. Tax paid on their sale can be refundable or their sale exempt if the items are not real property.

LIST B. Taxable Farm Supplies  
Which Are Not Machinery or Equipment

burlap*	lubricants
disposable hypodermic syringes	marking chalk
ear tags	packages for one-time use
hog rings	

\*Burlap is exempt when used in the form of a bag, container, wrap or other receptacle or packaging material.

## LIST C. Hand Tools—Taxable and Nontaxable

axes	lanterns
brooms	milk cans*
buckets	mops
cleaning brushes	paintbrushes
dehorner (nonelectric)*	pliers
garden hoses	scrapers
grease guns	screwdrivers
hammers	shovels
hay hooks*	wheelbarrows
hog ringers*	wrenches
lamps	

\*Hand tools specially designed for use in livestock or dairy production are equipment. Tax paid on the sale or use of these hand tools is refundable.

LIST D. Farm Machinery and Equipment Directly and  
Primarily Used in Livestock or Dairy Production.  
Tax Paid is Usually Refundable or the Sale Exempt.

artificial insemination equipment	gates*
augers*	grain augers
automatic feeding systems*	head gates
bulk feeding tanks*	heating pads and lamps
bulk milk coolers	hog feeders*
bulk milk tanks	hypodermic syringes and needles, nondisposable
cattle weaners and feeders	livestock feeding, watering and handling equipment*
cattle currying and oiling machines	loading chutes*
cattle feeders*	LP gas tanks
conveyers*	manure handling equipment*
dehorner, electric	milk coolers
electric fence equipment	milk strainers
fans*	milking machines
farrowing crates, houses and stalls*	refrigerators used to cool raw milk
feed bins*	silo unloaders
feed carts	specialized flooring*
feed elevators*	space heaters
feed grinders	sprayers
feed tanks*	squeeze chutes*
feeders	vacuum coolers
foggers	ventilators*
furnaces*	

\*If not real property. See 18.48(1)“c”(1).

**18.48(8) Seller's and purchaser's liability for sales tax.** The seller shall be relieved of sales tax liability if the seller takes from the purchaser an exemption certificate stating that the purchase is of machinery or equipment meeting the requirements of subrule 18.48(4). An exemption certificate can take the form of a stamp imprinted onto one of the documents of sale. If items purchased tax-free pursuant to an exemption certificate are used or disposed of by the purchaser in a nonexempt manner, the purchaser is solely liable for the taxes and shall remit the tax directly to the department.

This rule is intended to implement Iowa Code section 422.45 as amended by 1996 Iowa Acts, chapter 1145.

**701—18.49(422,423) Aircraft sales, rental, component parts, and services exemptions prior to, on, and after July 1, 1999.**

**18.49(1)** Prior to July 1, 1999, sales in Iowa of aircraft subject to registration were subject to sales tax. On and after July 1, 1999, sales of aircraft in Iowa are subject to Iowa use tax rather than Iowa sales tax. See rule 701—31.6(423). Also, on and after that date, the use tax imposed on sales of aircraft in Iowa is collected by the Iowa department of transportation at the time of the aircraft's registration. Sales of certain aircraft parts in Iowa, the performance of taxable services in Iowa on or in connection with the repair, remodeling, or maintenance of aircraft, and the rental of aircraft in Iowa remain subject to Iowa sales tax on and after July 1, 1999. See subrule 18.49(3).

**18.49(2)** For the purposes of this subrule only, an "aircraft" is any contrivance known or hereafter invented which is designed for navigation of or flight in the air and is used in a scheduled interstate Federal Aviation Administration certified air carrier operation.

*a. Exempt aircraft sales.* As of July 1, 1988, and up to and including June 30, 1999, gross receipts from the sale of aircraft are exempt from tax.

*b. Exempt rental of aircraft.* Effective May 1, 1995, and retroactive to July 1, 1988, the taxable rental (see 701—26.74(422,423)) of aircraft, as defined in the introductory paragraph of this subrule, is exempt from tax.

*c. Exempt sale or rental of aircraft parts.* Effective May 1, 1995, and retroactive to July 1, 1988, gross receipts from the sale or rental of tangible personal property permanently affixed to any aircraft as a component part of that aircraft are exempt from tax. The term "component parts" includes, but is not limited to, repair or replacement parts and materials.

*d. Exempt performance of services.* Effective May 1, 1995, and retroactive to July 1, 1988, gross receipts from the rendering, furnishing, or performing of services in connection with the repair, remodeling, or maintenance of aircraft (including aircraft engines and component materials or parts) are exempt from tax.

**18.49(3)** For the purposes of this subrule only, an "aircraft" is any aircraft used in a nonscheduled interstate Federal Aviation Administration certified air carrier operation conducted under 14 CFR ch. 1, pt. 135. On and after July 1, 1998, the gross receipts from the sale or rental of tangible personal property permanently affixed or permanently attached as a component part of these aircraft, including but not limited to repair or replacement materials or parts, are exempt from tax. Also exempt, on and after that date, are the gross receipts from the performance of any service used for aircraft repair, remodeling, or maintenance when the service is performed on an aircraft, aircraft engine, or aircraft component material or part exempt under this subrule. Gross receipts from the sale or rental of aircraft are not exempt from tax under this subrule

**18.49(4)** For the purposes of this subrule only, an "aircraft" is any contrivance known or hereafter invented which is designed for navigation of or flight in the air. On and after July 1, 1998, and up to and including June 30, 1999, the gross receipts from the sale of an aircraft to an aircraft dealer who rents or leases the aircraft to another are exempt from tax if all of the following circumstances exist:

- a.* The aircraft is kept in the inventory of the dealer for sale at all times.
- b.* The dealer reserves the right to immediately take the aircraft from the renter or lessee when a buyer is found.
- c.* The renter or lessee is aware that the dealer will immediately take the aircraft when a buyer is found.

As soon as an aircraft, the sale of which is exempt under this subrule, is used for any purpose other than leasing or renting, or the conditions set out in paragraphs “a,” “b,” and “c” are not continuously met, the dealer claiming the exemption is liable for the tax which would have been due but for the exemption set out in this subrule. Tax will be computed on the original purchase price paid by the dealer.

See rule 701—32.13(423) for a description of the manner in which transactions described in this subrule are exempted from tax on and after July 1, 1999.

This rule is intended to implement Iowa Code section 422.45, subsections 38, 38A, 38B and 38C and Iowa Code section 423.2 as amended by 1999 Iowa Acts, chapter 168.

**701—18.50(422,423) Property used by a lending organization.** On and after July 1, 1988, the gross receipts from the sale of tangible personal property to a nonprofit organization organized for the purpose of lending the tangible personal property to the general public for use by the public for nonprofit purposes are exempt from tax. The exemption contained in this rule is applicable to tangible personal property only, and not to taxable services. It is applicable to the sale of that property and not to its rental to a nonprofit organization. Finally, the exemption is applicable only to property purchased by a nonprofit organization for subsequent rental to the general public. The exemption is not applicable to other property (e.g., office equipment) which the nonprofit organization might need for its ongoing existence.

This rule is intended to implement Iowa Code section 422.45(36).

**701—18.51(422,423) Sales to nonprofit legal aid organizations.** On and after July 1, 1988, the gross receipts from the sale or rental of tangible personal property or from services performed, rendered, or furnished to a nonprofit legal aid organization are exempt from tax.

This rule is intended to implement Iowa Code subsection 422.45(37).

**701—18.52(422,423) Irrigation equipment used in farming operations.** On and after July 1, 1989, the gross receipts from the sale or rental of irrigation equipment used in farming operations are exempt from tax. The term “irrigation equipment” includes, but is not limited to, circle irrigation systems and trickle irrigation systems. The term “farming operations” has the same meaning as the term “agricultural production” set out in 701—subrule 17.9(3), paragraph “a,” and as further characterized in 18.44(2) “a.”

Effective May 18, 2001, and retroactive to April 1, 1995, the gross receipts from the sale or rental of irrigation equipment, as defined above, whether installed above or below ground are exempt from tax as long as the equipment is sold or rented by a contractor or farmer and the equipment is primarily used in agricultural operations.

Contractors or farmers entitled to the exemption set forth in the previous paragraph may apply for a refund of taxes, interest or penalties paid on the sale or rental of qualifying irrigation equipment for transactions that occurred between April 1, 1995, and May 18, 2001. To be eligible for refund, refund claims must be filed with the department prior to October 1, 2001. Refund claims are limited to \$25,000 in the aggregate and will not be allowed if not timely filed. If the amount of refund claims totals more than \$25,000 in the aggregate, the department will prorate the \$25,000 among all claimants in relation to the amounts of the claimants’ valid claims.

This rule is intended to implement Iowa Code section 422.45 and 2001 Iowa Acts, House File 723.

**701—18.53(422,423) Sales to persons engaged in the consumer rental purchase business.** On and after July 1, 1989, the gross receipts from the sale of tangible personal property, except vehicles subject to registration, to persons regularly engaged in the consumer purchase business are exempt from tax if the property (1) is sold for the purpose of utilization in a transaction involving a “consumer rental purchase agreement” as defined in Iowa Code subsection 537.3604(8), and (2) the gross receipts from the consumer rental of the property are subject to Iowa sales or use tax.

If property exempt under this rule is made use of for any purpose other than a consumer rental purchase, the person claiming the exemption is liable for the tax that would have been due had the exemption not existed. The tax shall be computed on the original purchase price to the person claiming

the exemption. The aggregate of the tax paid on the consumer rental purchase of the property, not exceeding the amount of sales or use tax owed, shall be credited against the tax.

This rule is intended to implement Iowa Code section 422.45(18).

**701—18.54(422,423) Sales of advertising material.** On and after July 1, 1990, gross receipts from the sales of advertising material to any person in Iowa are exempt from tax if that person, or any agent of that person, will, after the sale, send that advertising material outside of Iowa and subsequent sole use of that material will be outside this state.

For the purposes of this rule “advertising material” is tangible personal property only, including paper. “Advertising material” is limited to the following: brochures, catalogs, leaflets, fliers, order forms, return envelopes, floppy discs, CD-ROMs, videotapes, and any similar items of tangible personal property which will be used to promote sales of property or services.

This rule is intended to implement Iowa Code section 422.45.

**701—18.55(422,423) Drop shipment sales.** A “drop shipment” generally involves two sales transactions and three parties. The first party is a consumer located inside Iowa. The second party is a retailer located outside the state. The third party is a supplier who may be located inside or outside of Iowa. The two sales transactions in question are the sale of property from the supplier to the out-of-state retailer, and the further sale of that property from the out-of-state retailer to the consumer in Iowa.

A “drop shipment sale” occurs when the consumer places an order for the purchase of tangible personal property with the out-of-state retailer. The retailer does not own the property ordered at the same time the consumer’s order is placed. The retailer then purchases the property from the supplier. The supplier in turn ships the property directly to the consumer in Iowa. Under Iowa law the supplier in a drop shipment sale cannot be required to collect tax (either sales or use) from the consumer, even if the requisite “nexus” to require collection exists. See the next to last paragraph of this rule for a characterization of “nexus.” The supplier transfers possession of the goods to the consumer; however, transfer of possession alone has never been held to be a “sale” for the purposes of Iowa sales and use tax law. *Sturtz v. Iowa Department of Revenue*, 373 N.W.2d 131 (Iowa 1985) and *Cedar Valley Leasing v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979).

With reference to drop shipment sales: If delivery of the goods under the contract for sale has occurred outside of Iowa, sale of the goods has occurred outside of Iowa. If delivery of the goods under the contract for sale has occurred within Iowa, the sale has occurred here. See *Sturtz* above for more information regarding sales and delivery. If the sale has occurred in Iowa and the retailer possesses the requisite nexus to require it to collect Iowa tax, the retailer is obligated to collect Iowa sales tax upon the “gross receipts” from its sale of the goods to the consumer. If the sale has occurred outside this state, and the retailer possesses the nexus to require it to collect Iowa tax, the retailer is obligated to collect Iowa retailer’s use tax upon the purchase price of the goods. If the retailer does not have nexus sufficient to require it to collect either Iowa sales or Iowa use tax, or if the retailer fails to collect either tax, the consumer is obligated to pay a consumer use tax directly to the department upon the purchase price of the goods. These rules are illustrated in the following examples.

**EXAMPLE A:** A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The Minneapolis retailer contracts with a supplier in Iowa to manufacture and ship the goods to the consumer. The retailer has nexus with Iowa, and delivery under the contract for sale has occurred in this state. In this case, the consumer is obligated to pay and the retailer is obligated to collect Iowa sales tax. The supplier is not obligated to collect any Iowa tax.

**EXAMPLE B:** A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The Minnesota retailer contracts with a supplier in Iowa to manufacture and ship the goods to the consumer. The retailer has no nexus with Iowa. Delivery under the contract of sale is in Iowa. Under these circumstances, the consumer is obligated to pay consumer’s use tax directly to the department. Neither the retailer nor the supplier is obligated to collect any Iowa tax.

**EXAMPLE C:** A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier in Minneapolis to manufacture and ship the goods to

the consumer in Des Moines. The retailer has nexus with Iowa, and delivery under the contract for sale occurs in Iowa. Under these circumstances, the consumer is obligated to pay and the retailer is obligated to collect Iowa sales tax. The supplier is not obligated to collect any Iowa tax.

EXAMPLE D: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier in Minneapolis to manufacture and ship the goods to the consumer in Des Moines. The retailer has nexus with this state; delivery under the contract for sale is in Minnesota. Under the circumstances, the consumer is obligated to pay and the retailer is obligated to collect Iowa retailer's use tax. The supplier is not obligated to collect or pay any Iowa tax.

EXAMPLE E: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier in Minneapolis to manufacture and ship the goods to the consumer in Des Moines. The retailer has no nexus with this state. Delivery can occur in either Minnesota or Iowa. In this example, the consumer is obligated to pay Iowa consumer's use tax directly to the department. Neither the retailer nor the supplier is obligated to collect any Iowa tax.

EXAMPLE F: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier located in Madison, Wisconsin, to ship the goods to the consumer in Des Moines. The retailer has nexus with Iowa, and delivery under the contract for sale is in Iowa. Under these circumstances, the retailer is obligated to collect and the consumer obligated to pay Iowa sales tax. The supplier is not obligated to collect any Iowa tax.

EXAMPLE G: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier located in Madison, Wisconsin, to ship the goods to the consumer in Des Moines. The retailer has nexus with Iowa with delivery in Madison, Wisconsin. Under these circumstances, the retailer is obligated to collect and the consumer obligated to pay Iowa retailer's use tax. The supplier is not obligated to collect any Iowa tax.

EXAMPLE H: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier located in Madison, Wisconsin, to ship the goods to the consumer in Des Moines. The retailer has no nexus with Iowa. Delivery under the contract for sale may be in Iowa or Wisconsin. Under these circumstances, the consumer is obligated to pay Iowa consumer's use tax directly to the department. Neither the retailer nor the supplier is obligated to collect any Iowa tax.

As used in these examples, the requirement of "nexus" is discussed in *Good's Furniture House Inc. v. Iowa State Bd. of Tax Review*, 382 N.W.2d 145 (Iowa 1986); cert. den. 479 U.S. 817; *State Tax Commission v. General Trading Co.*, 10 N.W.2d 659, 233 Iowa 877 (1943) affd. 64 S.Ct. 1028, 322 U.S. 335, 88 L.Ed. 1309; and *Nelson v. Sears, Roebuck & Co.*, 292 N.W. 130, 228 Iowa 1273 (1940) reversed 61 S.Ct. 586, 312 U.S. 359, 85 L.Ed. 522, as well as other judicial decisions, and Iowa Code section 422.43(12).

This rule is intended to implement Iowa Code subsections 422.42(2) and 422.42(5).

**701—18.56(422,423) Wind energy conversion property.** On and after July 1, 1993, the gross receipts from the sale of property used to convert wind energy to electrical energy or the gross receipts from the sale of materials used to manufacture, install, or construct property used to convert wind energy to electrical energy shall be exempt from tax.

For the purposes of this rule, "property used to convert wind energy to electrical energy" means any device which converts wind energy to usable electrical energy including, but not limited to, wind chargers, windmills, wind turbines, pad mount transformers, substations, power lines, and tower equipment.

This rule is intended to implement Iowa Code section 422.45 as amended by 1993 Iowa Acts, chapter 161.

**701—18.57(422,423) Exemptions applicable to the production of flowering, ornamental, and vegetable plants.** On and after July 1, 1995, the production of flowering, ornamental, or vegetable plants by a grower in a commercial greenhouse or at another location is considered to be a part of agricultural production. The word "plants" does not include trees, shrubs, other woody perennials,

or fungus. The exemption also applies to implements, machinery, equipment, and replacement parts directly and primarily used in the production of flowering, ornamental, or vegetable plants and fuel used for providing heating or cooling for greenhouses or buildings or parts of buildings dedicated to the production of flowering, ornamental, or vegetable plants intended for sale in the ordinary course of business. The following exemptions are applicable to the production of flowering, ornamental, or vegetable plants.

**18.57(1)** Sales of fertilizer, limestone, herbicides, pesticides, insecticides, plant food, and medication for use in disease, weed, insect control, or other health promotion of flowering, ornamental, or vegetable plants to a commercial greenhouse are exempt from tax. For the purposes of this subrule a virus, bacteria, fungus, or insect which is purchased for use in killing insects or other pests is an “insecticide” or “pesticide.” See rules 701—17.4(422,423) and 17.9(422,423) for more information regarding these exemptions.

**18.57(2)** Sales of fuel to provide heating or cooling for a greenhouse or building or a part of a building dedicated to the production of flowering, ornamental, or vegetable plants held for sale in the ordinary course of business are exempt from tax. Electricity is a “fuel” for the purposes of this subrule. Fuel used in a plant production building for purposes other than heating or cooling (e.g., lighting) or for purposes other than direct use in plant production (e.g., heating or cooling office space) is not eligible for this exemption. For example, assume that there is a separate meter for electricity used only for heating or cooling. If a greenhouse is used, partially for growing plants and partially for a nonexempt purpose, a proportional exemption from sales tax may be claimed based upon a percentage calculated from a fraction, the numerator of which is the number of square feet of the greenhouse heated or cooled and used for raising plants, and the denominator of which is the number of square feet heated or cooled in the entire greenhouse. It may be necessary to alter this formula (by the use of separate metering, for example) if a greenhouse has a walk-in cooler and the cooler is used directly in plant production. Plant production has ended when a plant has grown to the point that it is of the size or weight at which it will be prepared for shipment to the destination where it will be marketed. Examples of nonexempt purposes for which a portion of a greenhouse might be used include, but are not limited to, portions used for office space, loading docks, storage of property other than plants, housing of heating and cooling equipment and portions used for packaging plants for shipment. See rule 701—15.3(422,423) regarding fuel exemption certificates and subrule 18.48(8) regarding seller’s and purchaser’s liability for sales tax.

**18.57(3)** Sales of gas, electricity, steam or other tangible personal property for use as a fuel in implements of husbandry used in the production of plants in a commercial greenhouse or elsewhere are exempt from tax. See 701—subrule 17.9(6), paragraph “a,” for a definition of “implements of husbandry.”

**18.57(4)** Sales of self-propelled implements. Sales of self-propelled implements or implements customarily drawn by or attached to self-propelled implements and replacement parts for the same are exempt from tax if the implements are used directly and primarily in the production of plants in commercial greenhouses or elsewhere. See rule 701—18.44(422,423) for an extensive explanation of this exemption. Implements exempt under this subrule include, but are not limited to, forklifts used to transport pallets of plants; wagons containing sterilized soil and tractors used to pull the same.

**18.57(5)** Sale of water used in the production of plants is exempt from tax. If water is not separately metered, the grower of plants must determine by use of a percentage that portion which is used for a taxable purpose and that portion which is used for an exempt purpose.

Nonexclusive examples of taxable usage would be rest rooms, sanitation, lawns, and vehicle wash.

**18.57(6)** For sales occurring on or after July 1, 1996, the gross receipts for the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case, or other similar article or receptacle sold for use in agricultural, livestock, or dairy production are not subject to sales tax. This exemption also applies to producers of ornamental, flowering, or vegetable plants in commercial greenhouses or other places which sell such items in the ordinary course of business since that activity is considered to be agricultural. A noninclusive list of containers and packaging materials would include boxes, trays, labels, sleeves, tape, and staples.

**18.57(7)** Sales of machinery and equipment used in plant production which are not self-propelled or attached to self-propelled machinery and equipment are also exempt from tax. See rule 701—18.48(422,423) for a thorough explanation of this exemption. Listed below are a number of examples of machinery and equipment which are directly and primarily used in plant production. Sales of this machinery and equipment to commercial growers are usually exempt from tax.

- Air-conditioning pads\*
- Airflow control tubes
- Atmospheric CO<sub>2</sub> control and monitoring equipment
- Backup generators
- Bins holding sterilized soil
- Control panels = heating and cooling
- Coolers used to chill plants\*
- Cooling walls\* or membranes
- Equipment used to control water levels for subirrigation
- Fans = cooling and ventilating\*
- Floor mesh for controlling weeds
- Germination chambers
- Greenhouse boilers\*
- Greenhouse netting or mesh = used for light and heat control
- Greenhouse monorail systems\*
- Greenhouse thermometers
- Handcarts used to move plants
- Lighting which provides artificial sunlight
- Overhead heating, lighting and watering systems
- Overhead tracks for holding potted plants\*
- Plant tables\*
- Plant watering systems\*
- Portable buildings used to grow plants\*
- Seeding and transplanting machines
- Soil pot and soil flat filling machines
- Steam generators for soil sterilization\*
- Warning devices = excess heat or cold
- Watering booms

\*If not real property. See 18.48(1) “c”(1).

**18.57(8)** Miscellaneous exempt and taxable sales. Sales of pots, soil, seeds, bulbs, and “starter plants” for use in plant production are not the sale of machinery or equipment, but can be sales for resale and exempt from tax if the pots and soil are sold with the final product or become the finished product. Sales of portable buildings which will be used to display plants for retail sales are taxable. Finally, sales of whitewash which will be painted on greenhouses to control the amount of sunlight entering those houses are taxable sales of a “supply” rather than exempt sales of equipment. See 18.48(1) “c”(2) relating to “supplies.” See rule 701—18.7(422,423) relating to containers, including packaging cases, shipping cases, wrapping materials, and similar items sold to retailers, and see subrule 18.57(6).

This rule is intended to implement Iowa Code sections 422.42(1), 422.42(4), 422.42(11), 422.45(39) and 422.47(4) and Iowa Code section 422.45 as amended by 1996 Iowa Acts, chapter 1145.

**701—18.58(422,423) Exempt sales or rentals of computers, industrial machinery and equipment, and exempt sales of fuel and electricity on and after July 1, 1997, but before July 1, 2016.** The sale or rental of machinery, equipment, or computers used by a manufacturer in processing; the sale or rental of a computer used in the processing or storage of data or information by an insurance company, financial institution, or commercial enterprise; and the sale or rental of various other types of tangible personal property are, under certain circumstances, exempt from tax as of July 1, 1997, but before July 1, 2016.

For sales that occur as part of a contract entered into on or after July 1, 2016, see rules 701—230.14(423) to 701—230.22(423).

**18.58(1) Definitions.** The following terms are defined for the purposes of this rule in the manner set out below.

*“Commercial enterprise”* includes businesses and manufacturers conducted for profit and includes centers for data processing services to insurance companies, financial institutions, businesses, and manufacturers, but excludes professions and occupations and nonprofit organizations. A hospital that is a not-for-profit organization would not be a “commercial enterprise.” The term “professions” means a vocation or employment requiring specialized knowledge and often long and intensive academic preparation. The term “occupations” means the principal business of an individual. Included within the meaning of “occupations” is the business of farming. A professional corporation which carries on any business which is a “profession” or “occupation” is not a commercial enterprise.

*“Computer”* means stored program processing equipment and all devices fastened to it by means of signal cables or any communication medium that serves the function of a signal cable. Nonexclusive examples of devices fastened by a signal cable or other communication medium are terminals, printers, display units, card readers, tape readers, document sorters, optical readers, and card or tape punchers. Excluded from the definition of “computer” is point-of-sale equipment. For a characterization of “point-of-sale equipment,” see 701—subrule 71.1(7). Also included within the meaning of the word “computer” is any software consisting of an operating system or executive program. Such software coordinates, supervises, or monitors the basic operating procedures of a computer. An operating system or executive program is exempt from sales tax only if purchased as part of the sale of the computer for which it operates. An operating system or executive program priced separately or sold at a later time is subject to the provisions of rule 18.34(422,423). Excluded from the meaning of the word “computer” is any software consisting of an application program. For purposes of this subrule, “operating system or executive program” means a computer program which is fundamental and necessary to the functioning of a computer. The operating system or executive program software controls the operation of a computer by managing the allocation of all system resources, including the central processing unit, main and secondary storage, input/output devices, and the processing of programs. This is in contrast to application software which is a collection of one or more programs used to develop and implement the specific applications which the computer is to perform, and which calls upon the services of the operating system or executive program.

*“Contract manufacturer”* is any manufacturer who falls within the definition of “manufacturer” set out subsequently in this subrule except that a contract manufacturer does not sell the tangible personal property which it processes on behalf of other manufacturers.

*“Directly used.”* Property is “directly used” only if it is used to initiate, sustain, or terminate an exempt activity. In determining whether any property is “directly used,” consideration should be given to the following factors:

1. The physical proximity of the property in question to the activity in which it is used;
2. The proximity of the time of use of the property in question to the time of use of other property used before and after it in the activity involved; and
3. The active causal relationship between the use of the property in question and the activity involved. The fact that a particular piece of property may be essential to the conduct of the activity because its use is required either by law or practical necessity does not, of itself, mean that the property is directly used.

*“Financial institution”* is a bank incorporated under any state or federal law; a savings and loan association incorporated under any state or federal law; a credit union organized under any state or federal law; or any corporation licensed as an industrial loan company under Iowa Code chapter 536A. Excluded from the meaning of the term are loan brokers governed by Iowa Code chapter 535C and production credit associations.

*“Insurance company”* means an insurer organized or operating under Iowa Code chapter 508, 514, 515, 518, 518A, 519, or 520 or authorized to do business in Iowa as an insurer or as a licensed insurance agent under Iowa Code chapter 522. Excluded from the definition of “insurance company” are fraternal

and beneficial societies governed by Iowa Code chapter 512 and health maintenance organizations governed by Iowa Code chapter 514B. This list of exclusions is not intended to be exclusive.

*“Machinery and equipment”* means machinery and equipment used by a manufacturer. Machinery is any mechanical, electrical, or electronic device designed and used to perform some function and to produce a certain effect or result. The term includes not only the basic unit of the machinery, but also any adjunct or attachment necessary for the basic unit to accomplish its intended function. The term also includes all devices used or required to control, regulate, or operate a piece of machinery, provided such devices are directly connected with or are an integral part of the machinery and are used primarily for control, regulation, or operation of machinery. Jigs, dies, tools, and other devices necessary to the operation of or used in conjunction with the operation of what would be ordinarily thought of as machinery are also considered to be “machinery.” See *Deere Manufacturing Co. v. Zeiner*, 247 Iowa 1264, 78 N.W.2d 527 (1956). Also see the definition of “replacement parts” *infra*. Machinery does not include buildings designed specifically to house or support machinery. Equipment is any tangible personal property used in an operation or activity. Nonexclusive examples of equipment are tables on which property is assembled on an assembly line and chairs used by assembly line workers.

*“Manufacturer”* means any person, firm, or corporation that purchases, receives, or holds personal property for the purpose of adding to its value by any process of manufacturing, refining, purifying, combining of different materials, or by packing of meats with an intent to sell at a gain or profit. Those who are in the business of printing, newspaper publication, bookbinding, lumber milling, and production of drugs and agricultural supplies are illustrative, nonexclusive examples of manufacturers. Construction contracting; remanufacture or rebuilding of tangible personal property (such as automobile engines); provision of health care; farming; transportation for hire; and the activities of restaurateurs, hospitals, medical doctors, and those who merely process data are illustrative, nonexclusive examples of businesses which are not manufacturers. See *Associated General Contractors of Iowa v. State Tax Commission*, 255 Iowa 673, 123 N.W.2d 922 (1963) and *River Products Co. v. Board of Review of Washington County*, 332 N.W.2d 116 (Iowa Ct. App. 1982). The term “manufacturer” includes a contract manufacturer. Ordinarily, the word does not include those commercial enterprises engaged in quarrying or mining. However, effective July 1, 1998, a commercial enterprise, the principal business of which is quarrying or mining, is a manufacturer with respect to activities in which it engages subsequent to quarrying or mining. These subsequent activities include, by way of nonexclusive example, crushing, washing, sizing, and blending of aggregate materials.

EXAMPLE: Company A owns and operates a gravel pit. It sells the gravel extracted from the pit to others who use the gravel for surfacing roads and as an ingredient in concrete manufacture. Company A removes overlay and raw gravel from the pit. It then transports the gravel to a plant where washing and sizing of the gravel take place. Company A is a manufacturer, but only with respect to those activities which occur after it severs the gravel from the ground.

*“Pollution control equipment”* means any disposal system or apparatus used or placed in operation primarily for the purpose of reducing, controlling, or eliminating air or water pollution. The term does not include any apparatus used to eliminate “noise pollution.” Liquid, solid, and gaseous wastes are included within the meaning of the word “pollution.” “Pollution control equipment” specifically includes, but is not limited to, any equipment the use of which is required or certified by an agency of this state or the United States Government. Wastewater treatment facilities and scrubbers used in smokestacks are examples of pollution control equipment. However, pollution control equipment does not include any equipment used only for worker safety (e.g., a gas mask).

*“Processing”* means a series of operations in which materials are manufactured, refined, purified, created, combined, transformed, or stored by a manufacturer, ultimately into tangible personal property. Processing encompasses all activities commencing with the receipt or producing of raw materials by the manufacturer and ending at the point products are delivered for shipment or transferred from the manufacturer. Processing includes, but is not limited to, refinement or purification of materials; treatment of materials to change their form, context, or condition; maintenance of the quality or integrity of materials, components, or products; maintenance of environmental conditions necessary for materials, components or products; quality control activities; construction of packaging and shipping

devices; placement into shipping containers or any type of shipping device or medium; and the movement of materials, components, or products until shipment from the manufacturer.

*“Processing or storage of data or information.”* All computers store and process information. However, only if the “final output” for a user or consumer is stored or processed data will the computer be eligible for exemption of tax.

*“Receipt or producing of raw materials”* means activities performed upon tangible personal property only. With respect to raw materials produced from or upon real estate, “production of raw materials” is deemed to occur immediately following the severance of the raw materials from the real estate.

*“Recycling”* means any process by which waste or materials which would otherwise become waste are collected, separated, or processed and revised or returned for use in the form of raw materials or products. The term includes, but is not limited to, the composting of yard waste which has been previously separated from other waste. “Recycling” does not include any form of energy recovery.

*“Replacement parts.”* A “replacement part” is any machinery, equipment, or computer part which is substituted for another part that has broken, has become worn out or obsolete, or is otherwise unable to perform its intended function. “Replacement parts” are those parts which materially add to the value of industrial machinery, equipment, or computers or appreciably prolong their lives or keep them in their ordinarily efficient operating condition. Excluded from the meaning of the term “replacement parts” are supplies, the use of which is necessary if machinery is to accomplish its intended function. Drill bits, grinding wheels, punches, taps, reamers, saw blades, lubricants, coolants, sanding discs, sanding belts, and air filters are nonexclusive examples of supplies. Sales of supplies remain taxable.

Tangible personal property with an expected useful life of 12 months or more which is used in the operation of machinery, equipment, or computers is rebuttably presumed to be a “replacement part.” Tangible personal property used in the same manner with an expected useful life of less than 12 months is rebuttably presumed to be a “supply.”

*“Research and development”* means experimental or laboratory activity which has as its ultimate goal the development of new products or processes of processing. Machinery, equipment, and computers are used “directly” in research and development only if they are used in actual experimental or laboratory activity that qualifies as research and development under this subrule.

**18.58(2) Exempt sales.** On and after July 1, 1997, sales or rentals of the following machinery, equipment, or computers (including replacement parts) are exempt from tax:

*a.* Machinery, equipment, and computers directly and primarily used in processing by a manufacturer.

*b.* Machinery, equipment, and computers directly and primarily used to maintain a manufactured product’s integrity or to maintain any unique environmental conditions required for the product.

*c.* Machinery, equipment and computers directly and primarily used to maintain unique environmental conditions required for other machinery, equipment, or computers used in processing by a manufacturer.

*d.* Test equipment directly and primarily used by a manufacturer in processing to control the quality and specifications of a product.

*e.* Machinery, equipment, or computers directly and primarily used in research and development of new products or processes of processing.

*f.* Computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise.

*g.* Machinery, equipment, and computers directly and primarily used in recycling or reprocessing of waste products.

*h.* Pollution control equipment used by a manufacturer. It is not necessary that the equipment be “directly and primarily” used in any kind of processing.

*i.* Materials used to construct or self-construct any machinery, equipment, or computer, the sale of which is exempted by paragraphs “a” through “h” above.

*j.* Exempt sales of fuel and electricity. Sales of fuel or electricity consumed by machinery, equipment, or computers used in any exempt manner described in paragraphs “a,” “b,” “c,” “d,” “e,”

“g,” and “h” of this subrule are exempt from tax. Sales of electricity consumed by computers used in the manner described in paragraph “f” remain subject to tax.

**18.58(3) Examples of exempt items.** Sales of the following nonexclusive types of machinery and equipment, previously taxable, are exempt on and after July 1, 1997, if that machinery or equipment is sold for direct and primary use in processing by a manufacturer: coolers which do not change the nature of materials stored in them; equipment which eliminates bacteria; palletizers; storage bins; property used to transport raw, semifinished, or finished goods; vehicle-mounted cement mixers; self-constructed machinery and equipment; packaging and bagging equipment (including conveyer systems); equipment which maintains an environment necessary to preserve a product’s integrity; equipment which maintains a product’s integrity directly; quality control equipment and electricity or other fuel used to power the machinery and equipment mentioned above.

**18.58(4) Processing—beginning to end.**

*a. The beginning of processing.* Processing begins with a manufacturer’s receipt or production of raw material. Thus, when a manufacturer produces its own raw material it is engaged in processing. Processing also begins when raw materials are transferred to a manufacturer’s possession by a manufacturer’s supplier.

*b. The completion of processing.* Processing ends when the finished product is transferred from the manufacturer or delivered for shipment by the manufacturer. Therefore, a manufacturer’s packaging, storage, and transport of a finished product after the product is in the form in which it will be sold at retail are part of the processing of the product.

*c. Examples of the beginning, intervening steps, and the ending of processing.* Of the following, Examples A and B illustrate when processing begins under various circumstances; Example C demonstrates the middle stages of processing; and Example D demonstrates when the end of processing takes place.

EXAMPLE A. Company A manufactures fine furniture. Company A owns a grove of walnut trees which it uses as raw material. A’s employees cut the trees, transport the logs to A’s factory, offload them there, and store the logs in a warehouse (to begin the curing of their wood) before taking them to A’s sawmill. The walnut trees are real property, *Kennedy v. Board of Assessment and Review*, 276 N.W. 205, 224 Iowa 405 (1937). Thus, no “production of raw materials” has occurred with regard to the trees until they have been severed from the soil and transformed into logs. In this example, “processing” of the logs begins when they are placed on vehicles for transport to A’s factory. However, note that even though the transport vehicles are used in processing, if they are “vehicles subject to registration,” their use is not exempt from tax. See 18.58(6)“d” infra.

EXAMPLE B. Company A from the previous example also buys mahogany logs from a supplier in Honduras. Company A uses its own equipment to offload the logs from railroad cars at its manufacturing facility and then transports, stores, and saws the logs as previously described in Example A. Processing begins when Company A offloads the logs from the railroad cars.

EXAMPLE C. Company C is a microbrewery. It uses a variety of kettles, vats, tanks, tubs, and other containers to mix, cook, ferment, settle, age, and store the beer which it brews. It also uses a variety of pipes and pumps to move the beer among the various containers involved in the activity of brewing. All stages of this brewing are part of processing whether those stages involve the transformation of the raw materials from one state to another, e.g., fermentation or aging, or simply involve holding the materials in an existing state, e.g., storage of hops in a bin or storage of the beer immediately prior to bottling. Also, any movement of the beer between containers is an activity which is a part of processing, whether this movement is an “integral part” of the production of the beer or not.

EXAMPLE D. After the brewing process is complete, Company C places its beer in various containers, stores it, and moves the beer to its customers by a common carrier that picks up the beer at C’s brewery. C’s activities of placing the beer into bottles, cans, and kegs, storing it after packaging, and moving the beer by use of a forklift to the common carrier’s pickup site are activities which are part of processing.

**18.58(5) Various unrelated inclusions in and exclusions from this exemption.**

*a.* The following are nonexclusive examples of machinery which is not directly used in processing:

(1) Machinery used exclusively for the comfort of workers. Examples are air cooling, air conditioning, and ventilation systems.

(2) Machinery used in support operations, such as a machine shop, in which production machinery is assembled, maintained, or repaired.

(3) Machinery used by administrative, accounting, and personnel departments.

(4) Machinery used by plant security, fire prevention, first aid, and hospital stations.

(5) Machinery used in plant communications and safety.

*b.* The following is an example of property directly used in research and development. Frontier Hybrid, Inc. maintains a research and development laboratory for use in developing a corn plant which is a perennial. It purchases the following items for use in its research and development laboratory: a computer which will process data relating to the genetic structure of the various corn plants which Frontier Hybrid is testing, an electron microscope for examining the structure of corn plant genes, a “steam cleaner” for cleaning rugs in the laboratory offices, and a typewriter for use by the laboratory director’s secretary. The computer and the microscope are “directly” used in the research in which the laboratory is engaged; the steam cleaner and the typewriter only indirectly used. Therefore, purchase of the computer and microscope would be exempt from tax; purchase of the steam cleaner and typewriter would be subject to tax.

*c.* The following is an example of computers used and not used in processing or storage of information or data. A health insurance company has four computers. Computer A is used to monitor the temperature within the insurance company’s building. The computer transmits messages to the building’s heating and cooling systems telling them when to raise or lower the level of heating or air conditioning as needed. Computer B is used to store patient records and will recall those records on demand. Computer C is used to tabulate statistics regarding the amount of premiums paid in and the amount of benefits paid out for various classes of insured. Computer D is used to train the insurance company’s employees to perform various additional tasks or to better perform work they can already do. Computer D uses various canned programs to accomplish this. The “final output” of Computer A is neither stored nor processed information. Therefore, Computer A does not fit the definition of an exempt computer. The final output of Computer B is stored information. The final output of Computer C is processed information. The final output of Computer D is processed information consisting of the training exercises appearing on the computer monitor. The sale, lease, or use of Computers B, C, and D would qualify for exemption.

*d.* The following is an example of property not used in processing. A manufacturing plant located in Warren County which manufactures widgets fabricates its own patterns used in manufacturing the widgets on a metal press machine in its machine shop located in Story County. The machine shop does not sell the patterns, and the metal press machine is used for no other purpose than to fabricate the patterns. The metal press machine is not used in processing because there is no intent to sell the patterns used by the machine shop at a gain or profit.

**18.58(6) Exceptions.** Sales of the following machinery, equipment, or computers are not exempt:

*a.* Machinery, equipment, or computers assessed by the department of revenue pursuant to Iowa Code chapters 428, 433, 434, and 436 to 438, inclusive. For electric, gas, water, and other companies assessed under Iowa Code chapter 428, only property owned by the company is assessed by the department. For railroad, telephone, pipeline, and electric transmission lines companies, property leased to, as well as owned by, the company is assessed by the department. See 701—Chapters 71 and 77.

*b.* Hand tools. These are tools which can be held in the hand or hands and which are powered by human effort.

*c.* Point-of-sale equipment. See 701—subrule 71.1(7).

*d.* Vehicles subject to registration, except vehicles subject to registration which are directly and primarily used in recycling or reprocessing of waste products.

*e.* Machinery and equipment purchased by a person engaged in processing who is not a manufacturer. Restaurants, retail bakeries, food stores, and blacksmith shops are nonexclusive examples of businesses which process tangible personal property but are not manufacturers as that word is defined for the purposes of this rule.

*f.* The fact that the acquisition cost of rented or purchased machinery, equipment, or computers can be capitalized for the purposes of Iowa or federal income tax law is not an indication that their sale or rental would be exempt from tax under this rule.

**18.58(7)** *Lessor purchases of machinery, equipment, or computers.* The analysis regarding lessor purchases of farm machinery and equipment contained in subrule 18.44(3) explains that same problem regarding machinery, equipment, and computers.

**18.58(8)** *Designing or installing new industrial machinery or equipment.* The gross receipts from the services of designing or installing new industrial machinery or equipment are exempt from tax. The enumerated services of electrical or electronic installation are included in this exemption. To qualify for the exemption, the sale or rental of the machinery or equipment must be subject to exemption under this rule. In addition, the machinery or equipment must be “new.” For purposes of this subrule, “new” means never having been used or consumed by anyone. The exemption is not applicable to reconstructed, rebuilt, or repaired or previously owned machinery or equipment. The exemption is applicable to new machinery and equipment designed or installed for rental as well as for sale. The gross receipts from design or installation must be separately identified, charged separately, and reasonable in amount for the exemption to apply. A “computer” is not considered to be machinery or equipment, and its installation or design is not eligible for this exemption.

**18.58(9)** *Property used in recycling or reprocessing of waste products.* Gross receipts from the sale or rental of machinery (including vehicles subject to registration), equipment, or computers directly and primarily used in the recycling or reprocessing of waste products are exempt from tax. “Reprocessing” is not a subcategory of “processing.” Reprocessing of waste products is an activity separate and independent from the processing of tangible personal property. Machinery or equipment used in the recycling or reprocessing of waste products includes, but is not limited to, compactors, balers, crushers, grinders, cutters, or shears directly and primarily used for this purpose. The sale of an end loader, forklift, truck, or other moving device is exempt from tax if the device is directly and primarily used in the movement of property which is an integral part of recycling or reprocessing. The sale of a bin for storage ordinarily would not be exempt from tax; storage without more activity would not be a part of recycling or reprocessing. Certain limits for exemption placed upon industrial machinery and equipment are not applicable to machinery and equipment used in recycling or reprocessing. For example, the exemption will apply even if the machinery, equipment or computer is purchased by a person other than an insurance company, financial institution or commercial enterprise. A person engaged in a profession or occupation could purchase property for direct and primary use in recycling or reprocessing of waste products and the exemption would apply.

*a.* By way of nonexclusive examples, recycling or reprocessing can begin when waste or material which would otherwise become waste is collected or separated. A vehicle used directly and primarily for collecting waste which will be recycled or reprocessed could be a vehicle used for an exempt purpose under this rule. Thus, the purchaser of a garbage truck could claim this exemption if the truck were directly and primarily used in recycling and not, for instance, in hauling garbage to a landfill. Machinery or equipment used to segregate waste from material to be recycled or reprocessed or used to separate various forms of materials which will be reprocessed (e.g., glass and aluminum) can also be used at the beginning of recycling or reprocessing.

*b.* Machinery and equipment directly and primarily used in recycling or reprocessing. See subrule 18.58(1) for the definition of “directly used” which is applicable to this subrule. The examples of machinery not directly used in processing set out in 18.58(5) “a” should be studied for guidance in determining whether similar machinery is or is not used in recycling or reprocessing; e.g., machinery used in plant security (see 18.58(5) “a”(4)) is not machinery directly used in recycling or reprocessing.

*c.* Integral use in recycling or reprocessing. Ordinarily, any operation or series of operations which does not transform waste or material which would otherwise become waste into new raw materials or products would not be a part of recycling or reprocessing. However, activities which do not do this, but are an “integral part” of recycling or reprocessing, are themselves recycling or reprocessing. For example, an endless belt which moves aluminum cans from a machine where they are shredded to a machine where the shredded aluminum is crushed into blocks would be an endless belt used in recycling

or reprocessing and the exemption applies. See subrule 18.29(5) for a discussion of when an activity is an integral part of “processing.” Some of that discussion is applicable to this subrule.

*d.* The end of recycling or reprocessing. Recycling or reprocessing ends when waste or a material which would otherwise become waste is in the form of raw material or in the form of a product. For instance, a corporation purchases a machine which grinds logs, stumps, pallets, crates, and other waste wood into wood chips. After grinding, the wood chips are sold and transported to various sites where the chips are dumped and spread out over the ground for use in erosion control. The machine which grinds the wood chips is a machine used in recycling. The truck which transports the wood chips from the machine to the sites is not used in recycling because at the time the chips are placed in the truck they are in the form in which they will be used in erosion control.

This rule is intended to implement Iowa Code Supplement section 422.45(27) as amended by 1998 Iowa Acts, Senate File 2288; Iowa Code section 422.45(29); and Iowa Code chapter 423. [ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—18.59(422,423) Exempt sales to nonprofit hospitals.** On and after July 1, 1998, the gross receipts from sales or rentals of tangible personal property to and from the rendering, furnishing, or performing of services for a nonprofit hospital licensed under Iowa Code chapter 135B are exempt from tax if the property or service purchased is used in the operation of the hospital. A hospital is not entitled to claim a refund for tax paid by a contractor on the sale or use of tangible personal property or the performance of services in the fulfillment of a written construction contract with the hospital. However, see the circumstances set out below in which sales of goods, wares or merchandise, or taxable services to a hospital for use in the fulfillment of a construction contract, are exempt from Iowa tax.

For the purposes of this rule, the word “hospital” means a place which is devoted primarily to the maintenance and operation of facilities for diagnosis, treatment, or care, over a period exceeding 24 hours, of two or more nonrelated individuals suffering from illness, injury, or a medical condition (such as pregnancy). The word “hospital” includes general hospitals, specialized hospitals (e.g., pediatric, mental, and orthopedic hospitals, and cancer treatment centers), sanatoriums, and other hospitals licensed under Iowa Code chapter 135B. Also included are institutions, places, buildings, or agencies in which any accommodation is primarily maintained, furnished, or offered for the care, over a period exceeding 24 hours, of two or more nonrelated aged or infirm persons requiring or receiving chronic or convalescent care. Excluded from the meaning of the term “hospital” are institutions for well children; day nursery and child care centers; foster boarding homes and houses; homes for handicapped children; homes, houses, or institutions for aged persons which limit their function to providing food, lodging, and provide no medical or nursing care, and house no bedridden person; dispensaries or first-aid stations maintained for the care of employees, students, customers, members of any commercial or industrial plan, educational institution, or convent; freestanding hospice facilities which operate a hospice program in accordance with 42 CFR § 418 and freestanding clinics which do not provide diagnosis, treatment, or care for periods exceeding 24 hours. This list of inclusions and exclusions is not exclusive. For additional information see 481—Chapter 51.

Ordinarily, goods, wares, or merchandise (such as building materials, supplies, and equipment; see rule 701—19.3(422,423) for definitions) which is purchased by a hospital and used by a contractor in the fulfillment of a written contract with the hospital cannot be purchased exempt from Iowa tax. The goods, wares, and merchandise used in the fulfillment of these construction contracts are not used in the “operation” of a hospital but in activities at least one step removed from that operation. See *Polich v. Anderson-Robinson Coal Co.*, 227 Iowa 553, 288 N.W. 650 (1939).

However, for a limited period, the gross receipts from all sales of goods, wares, or merchandise or from services rendered, furnished, or performed are exempt from tax (or a claim for refund may be filed for tax paid) if the tangible personal property or the taxable service is used in the fulfillment of a written construction contract with a hospital and all of the following circumstances exist:

1. Deliveries under contracts of sale of the goods, wares, or merchandise occurred or the taxable services were rendered, furnished, or performed between July 1, 1998, and December 31, 2001, inclusive. A claim for refund may be filed for any tax paid for this period, so long as the claim is filed prior to April

1, 2002, and the requirements of “2” and “3” below are also met. Claims for refunds of tax, interest, or penalty paid for the period of July 1, 1998, to December 31, 2001, are limited to \$25,000 in the aggregate. If the amount of the claimed refunds for this period totals more than \$25,000, the department must prorate the \$25,000 among all claimants in relation to the amounts of the claimants’ valid claims.

2. The written construction contract was entered into prior to December 31, 1999, or bonds to fund the construction were issued prior to December 31, 1999.

3. The property or services were purchased directly by the hospital or by a contractor as an agent of the hospital. For the purposes of this exemption, no hospital can retroactively designate a contractor to be its agent and by this means transform a contractor’s purchases of goods, wares, merchandise, or services into its own. Upon the department’s request, a hospital claiming that a contractor is or has been its purchasing agent must present suitable evidence of a principal-agent relationship between itself and the contractor during any period for which exempt sales or a refund is claimed. The best evidence of a principal and purchasing agent relationship is a written document setting out the terms of the relationship and the period for which the agency is in effect; however, other evidence, which is the equivalent of a written document in reliability, will be considered by the department when necessary.

This rule is intended to implement Iowa Code Supplement section 422.45 as amended by 2000 Iowa Acts, chapter 1207.

**701—18.60(422,423) Exempt sales of gases used in the manufacturing process.** Effective May 24, 1999, but retroactive to January 1, 1991, sales of argon and other similar gases to be used in the manufacturing process are exempt from tax. For the purposes of this rule, only inert gases are gases which are similar to argon. An “inert gas” is any gas which is normally chemically inactive. It will not support combustion and cannot be used as either a fuel or as an oxidizer. Argon, nitrogen, carbon dioxide, helium, neon, krypton, and xenon are nonexclusive examples of inert gases. Oxygen, hydrogen, and methane are nonexclusive examples of gases which are not inert. These sales are exempt only if the gas is purchased by a “manufacturer,” for used in “processing,” as those terms are defined in subrule 18.45(1), for the period prior to July 1, 1997, and as those terms are defined in subrule 18.58(1) for the period beginning July 1, 1997.

This rule is intended to implement Iowa Code section 422.45 as amended by 1999 Iowa Acts, chapter 170.

**701—18.61(422,423) Exclusion from tax for property delivered by certain media.** For the period beginning March 15, 1995, a taxable “sale” of tangible personal property does not occur if the substance of the transaction is delivered to the purchaser digitally, electronically, or by utilizing cable, radio waves, microwaves, satellites, or fiber optics. This exclusion from tax is not applicable to any leasing of tangible personal property, a lease not being a “sale” of tangible personal property for the purposes of Iowa sales and use tax law, *Cedar Valley Leasing, Inc. v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979). The exclusion is also not applicable to property delivered by any medium other than those listed above. Sales of items such as artwork, drawings, photographs, music, electronic greeting cards, “canned” software (see subrule 18.34(1)), entertainment properties (e.g., films, concerts, books, and television and radio programs), and all other digitized products delivered as described above are not taxable, except the exclusion does not repeal by implication the tax on the service of providing pay television. See rule 701—26.56(422). If an order for a product is placed by way of any of the media described above but the product ordered is delivered by conventional, physical means, e.g., the U.S. Postal Service or common carrier, sale of the product is not excluded from tax under this rule.

This rule is intended to implement Iowa Code Supplement section 422.43 as amended by 2002 Iowa Acts, Senate File 2321.

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CHAPTER 219  
SALES AND USE TAX ON CONSTRUCTION ACTIVITIES

Rules in this chapter include cross references to provisions in 701—Chapters 15 to 20, 21, 26, 30, 32 and 33 that were applicable prior to July 1, 2004.

**701—219.1(423) General information.** 2005 Iowa Code subsection 423.2(1) imposes a tax upon the sales price from the sales of tangible personal property, consisting of goods, wares or merchandise sold at retail in this state to consumers and users. Also subject to tax are certain enumerated services. Those services relating to the construction industry include carpentry; roof, shingle and glass repair; electrical repair and installation; excavating and grading; house and building moving; laboratory testing; landscaping; machinery operator services; machine repair of all kinds; oilers and lubricators; painting, papering, and interior decorating; pipe fitting and plumbing; wood preparations; termite, bug, roach, and pest eradicators; tin and sheet metal repair; welding; well drilling; and wrecking services. Under Iowa law, contractors are consumers or users of certain tangible personal property. Contractors may also be retailers of tangible personal property and taxable enumerated services. It should be noted that these services are exempt from taxation when performed on or in connection with new construction, reconstruction, alteration, expansion, or remodeling of a building or structure. The services of a general building contractor, architect or engineer are exempt from tax when performed on or in connection with new construction, reconstruction, alteration, expansion, or remodeling of a building or structure. For the purposes of this exemption, a structure is defined as that which is artificially built up or composed of parts joined together in some definite manner and which also has some obvious or apparent functional use or purpose. Nonexclusive examples of structures include buildings; roads, whether paved or otherwise; dikes; drainage ditches; and ponds. See rule 701—219.12(423) relating to structures.

This chapter details the obligation of contractors, contractor-retailers, retailers, and repairpersons to pay or collect sales tax on the sales price from sales of building materials, supplies, equipment, and other tangible personal property and the obligation of these parties to collect tax or claim exemption for their performances of taxable services. How one is classified, whether as a contractor, contractor-retailer, retailer, or repairperson is the basis for determining many of those obligations. It can be very difficult for a person starting a business to determine if that business will be engaged in contracting, retailing, a combination of the two, or providing repair services. However, one status must be chosen. Any reasonable assessment of a new business's status will be honored by the department. A status, once chosen, should not be changed, unless it has become clear from an extended course of dealing that the business has become something other than what it was established to be. For instance, if a business is founded to engage in contracting and purchases construction materials based on the fact that it is a contractor, but the founder must sell construction materials at retail if the business is to survive, and after two years' operation half the revenue is from construction contracts and half from retail sales, then the business has become a contractor-retailer and henceforth should purchase construction materials based on that status. Changing the status of a business from job to job to avoid the obligation to pay or collect tax is not a lawful activity.

2005 Iowa Code section 423.5 imposes a tax that is assessed upon tangible personal property purchased for use in this state and on taxable services which are rendered, furnished or performed in Iowa or where the product or result of such service is used in Iowa. "Use" of tangible personal property in Iowa is defined to mean and include the exercise by any person of any right or power over tangible personal property incident to the ownership of that property.

**701—219.2(423) Contractors—consumers of building materials, supplies, and equipment by statute.** 2005 Iowa Code subsection 423.2(1)"b" provides that sales of building materials, supplies and equipment to owners, contractors, subcontractors or builders for the erection of buildings or the alteration, repair or improvement of real property are retail sales in whatever quantity sold. This means that a contractor, subcontractor, or builder cannot claim an exemption for resale when purchasing building materials or supplies even if the contractor, subcontractor, or builder later separately itemizes

material and labor charges for construction contracts. Building materials and supplies would generally consist of items which are incorporated into real property, lose their identity as tangible personal property and cannot be removed without altering the realty, or which are consumed by the contractor during the performance of the construction contract. See subrules 219.3(1), 219.3(2) and 219.3(3). Building equipment would ordinarily consist of machinery and tools. See subrule 219.3(4). The fact that a contractor, subcontractor or builder holds an Iowa retail sales tax permit and has a tax number does not entitle that person to purchase building materials, supplies and equipment without paying sales tax to the vendor. See rules 701—219.3(423) and 701—219.4(423).

When bidding on a contract, a contractor (general, special or subcontractor) should anticipate that sales or use taxes will increase the cost of materials by the tax unless the sponsor is a designated exempt entity; reference 701—subrule 19.12(5). The necessary allowance should be made in figuring the bid inasmuch as the contractor will be held responsible for paying the tax on building supplies, materials and equipment. The tax should not be identified as a separate item in the formal bid since the contractor cannot charge sales tax.

**701—219.3(423) Sales of building materials, supplies, and equipment to contractors, subcontractors, builders or owners.** Suppliers or dealers that sell materials and supplies to contractors, subcontractors, builders or owners are required to collect Iowa sales tax from those persons based upon the sales price from such sales. Reference 701—subrule 19.12(5), which deals with construction contracts with designated exempt entities, for an explanation of one of the few exceptions to this requirement. The fact that a contractor, subcontractor, or builder holds an Iowa retail sales tax permit and has a tax number does not entitle that person to purchase building materials, supplies and equipment without paying sales tax to the vendor. See rules 701—219.2(423) and 701—219.4(423). Materials purchased out of state for use in Iowa are subject to the Iowa use tax which is payable in the quarter that the materials are delivered into the state.

**219.3(1) Building materials.** The term “building materials” as used in this rule means materials used in construction work, and is not limited to materials used in constructing a building with sides and covering. The term may also include any type of materials used for improvement of the premises or anything essential to the completion of a building or structure for the use intended. *State v. James A. Head & Company, Inc.*, 306 So. 2d 5 (Ala. 1974).

**219.3(2) Building supplies.** The term “building supplies” as used in this rule means anything that is furnished for and used directly in the carrying on of the work of an owner, contractor, subcontractor or builder and which is used or consumed by the contractor. Such items do not have to enter into and become a physical part of the structure like building materials, but they do become as much a part of the structure as the labor which is performed on it. *United States Fidelity & Guaranty Co. v. Feenaughty Machinery Co.*, 85 P.2d 1085, 197 Wash. 569.

**219.3(3) Typical items.** While not intended to be inclusive, the following is a list of typical items regarded as building materials and supplies:

- Asphalt
- Bricks
- Builders’ hardware
- Caulking material
- Cement
- Central air conditioning
- Cleaning compounds
- Conduit
- Doors
- Ducts
- Electric wiring, connections, and switching devices
- Fencing materials
- Flooring<sup>1</sup>
- Glass

Gravel  
Insulation  
Lath  
Lead  
Lighting fixtures  
Lime  
Linoleum<sup>1</sup>  
Lubricants  
Lumber  
Macadam  
Millwork  
Modular and mobile homes  
Mortar  
Oil  
Paint  
Paper  
Piping, valves, and pipe fittings  
Plaster  
Plates and rods used to anchor masonry foundations  
Plumbing supplies  
Polyethylene covers  
Power poles, towers, and lines  
Putty  
Reinforcing mesh  
Rock salt  
Roofing  
Rope  
Sand  
Sheet metal  
Steel  
Stone  
Stucco  
Tile  
Wallboard  
Wall coping  
Water conditioners  
Weather stripping  
Windows  
Window screens  
Wire netting and screen  
Wood preserver

**219.3(4)** *Building equipment.* The term “building equipment” as used in this rule means any vehicle, machine, tool, implement or other device used by a contractor in erecting structures for others, or reconstructing, altering, expanding or remodeling property of others which does not become a physical component part of the property upon which work is performed, and which is not necessarily consumed in the performance of such work. “Building equipment” includes, but is not limited to, such items as:

Compressors  
Drill presses  
Electric generators  
Forms  
Hand tools

Lathes  
Replacement parts for equipment  
Scaffolds  
Tools  
Vehicles including grading, lifting and excavating vehicles

Construction equipment purchased by a contractor which is intended for use in the performance of an Iowa construction contract is subject to the Iowa sales or use tax. Equipment which is rented for use on or in connection with an Iowa construction contract would normally be rented subject to tax. See rule 701—219.21(423) for an explanation of the existing exemption in favor of rented machinery used by a contractor on a job site.

<sup>1</sup> Floor coverings which are shaped to fit a particular room or area and which are attached to the supporting floor with cement, tacks or tack strips or by some other method making a permanent attachment are considered to be building materials. Reference rule 701—16.48(422,423) for an exception concerning carpeting. Carpeting (whether attached to the floor or not) is not treated as a building material for the purposes of this chapter. Rugs, mats and linoleum types of floor coverings which are not attached but which are simply laid on finished floors are also not considered to be building materials.

**701—219.4(423) Contractors, subcontractors or builders who are retailers.** In some instances, contractors, subcontractors and builders are in a dual business which includes reselling to the general public on a recurring “over-the-counter” basis the same type of building materials and supplies which are used by the contractors, subcontractors and builders in their own construction work. A person operating in such a manner is referred to in this rule as a contractor-retailer. Any person who is engaged in the performance of construction contracts and who also sells building materials or other items at retail is obligated to examine the person’s business and determine if it is that of a contractor or a contractor-retailer. A sale by a contractor-retailer of building materials, supplies and equipment which does not provide for installation of the merchandise sold is considered a retail sale and subject to sales tax. Conversely, a sale by a contractor-retailer of building supplies, materials and equipment which provides for installation of the merchandise is considered a construction contract and tax shall be paid by the contractor-retailer based upon the cost of materials at the time the materials are withdrawn from inventory for use in a construction contract performed in Iowa. When a contractor-retailer does repair work, the contractor-retailer is acting as a retailer and not a contractor and must collect tax on the sales price charged for materials used in the repair and on the sales price charged for any labor used in the repair which is a taxable service or on the entire charge if materials and labor are not separately invoiced. Reference rule 701—18.31(422,423) and rule 701—219.13(423).

The following is a list of the characteristics of the usual contractor-retailer:

1. A contractor-retailer is a business which makes frequent retail sales to the public or to other contractors and also engages in the performance of construction contracts (see rule 701—219.8(423)). In determining whether a business is a contractor-retailer or a retailer only, the department looks to the totality of business activity and not only to one portion of the business’s activity. Thus, the maintenance of a small retail outlet does not automatically transform a contractor-retailer into a retailer, and a large number of retail sales without a retail outlet can qualify a business as a contractor-retailer.

2. A business cannot claim the status of a contractor-retailer unless the business is in possession of a valid sales tax permit to report tax due from retail sales and from withdrawals of materials or supplies from inventory for use in construction contracts.

3. A contractor-retailer must purchase building materials, supplies, and equipment placed in its inventory for resale; the contractor-retailer should not pay sales or use tax to its suppliers for these items. Instead, the contractor-retailer should provide suppliers with valid resale exemption certificates. When a valid certificate is furnished, the vendor is relieved from the responsibility of collecting the tax if the purchaser has demonstrated that the purchaser is a contractor-retailer under the provisions of this rule. Reference rule 701—15.3(422,423) and rule 701—219.19(423) for a detailed explanation of this matter.

4. A contractor-retailer purchasing construction material which will not be placed in its inventory must purchase that material subject to Iowa sales or use tax. For example, if a contractor-retailer purchases wet concrete for use in a construction project, that purchase is taxable.

5. A contractor-retailer usually has a retail outlet, but if not, frequent sales to individuals or other contractors qualify a business as a contractor-retailer.

6. Contractor-retailers do not pay tax on materials withdrawn from inventory for use in construction projects performed outside Iowa. See 2005 Iowa Code subsection 423.2(1)“b.”

The business records of a contractor-retailer must clearly reflect the use made of items purchased, and the records must be in such form that the director can readily determine that the proper sales and use tax liability is being reported and paid.

The following examples are offered to illustrate the responsibility for paying and remitting sales tax under this rule:

EXAMPLE 1. ABC Company operates a retail outlet that sells lumber and other building materials and supplies. ABC Company is also a contractor which builds residential and commercial structures. ABC Company would be considered a contractor-retailer and would, therefore, purchase all inventory items for resale. Those items which are used in the performance of a construction contract would be subject to tax in the period that they are withdrawn from inventory. The tax would be computed on the cost of the items withdrawn from inventory. Those items which are sold over the counter in the retail outlets would be subject to tax at the time of sale. The tax would be computed on the over-the-counter sales price.

EXAMPLE 2. EFG Company is a mechanical contractor and has no retail outlets. EFG Company rarely sells any of its inventory to other persons or to other contractors. EFG Company would not be considered a contractor-retailer under this rule. However, EFG Company would be considered a contractor and must pay tax to its vendor at the time it purchases any building materials, supplies and equipment. However, on those rare occasions when an inventory item is sold to another person or to another contractor, tax must be collected at the time of sale; therefore, EFG Company should have a sales tax permit. An adjustment can be made to the sales tax report by taking a credit for tax previously paid on the item sold.

EXAMPLE 3. Home Town Construction Company is owned and operated by two individuals in a rural Iowa farming community. They do not have a retail outlet but they frequently make sales of building materials which are in their inventory to local residents. Home Town Construction Company would be a contractor-retailer and could purchase all inventory items for resale. Those items which are used in the performance of a construction contract would be subject to tax in the period they are withdrawn from inventory. The tax would be computed on the cost of the items withdrawn from inventory. Those items which are sold to residents would be subject to the tax at the time of sale. The tax would be computed on the sales price of the items.

EXAMPLE 4. Down Home Construction Company is operated by two individuals in a rural Iowa farming community. They do not have a retail outlet and rarely make sales of building materials from their inventory to local residents. Down Home Construction Company would not be considered a contractor-retailer under this rule. Rather, Down Home Construction Company would be considered a contractor and must pay tax to its vendor at the time it purchases any building materials, supplies and equipment. When sales are made to local residents, tax must be collected at the time of sale; therefore, Down Home Construction Company should have a sales tax permit. However, Down Home Construction Company can adjust its sales tax report by taking a credit for tax paid to its vendor on an item sold to a local resident.

EXAMPLE 5. Intown Home Construction Company places modular homes on slabs or basement foundations; makes electrical, plumbing and other connections; and otherwise prepares the modular homes for sale as real estate. Intown also has a sales tax permit, maintains an inventory of modular homes for sale, and sells homes from the inventory as tangible personal property to owners who later convert the property to real estate. Intown is a contractor-retailer and is obligated to pay or collect sales tax, respectively, at the time a modular home is withdrawn from inventory for use as material in a construction contract or at the time a modular home is withdrawn from inventory for sale to an owner. See rule 701—231.11(423) for an explanation of the basis on which tax is computed.

EXAMPLE 6. Smith’s Plumbing has a retail store in Davenport, but it also installs plumbing fixtures and lines in new construction and remodeling projects. Plumbing supplies that are taken from an

inventory in Davenport for a new home being built in Rock Island, Illinois, are withdrawn exempt from Iowa sales tax because the construction contract is performed outside Iowa. However, those supplies may be subject to Illinois sales or use tax.

**701—219.5(423) Building materials, supplies, and equipment used in the performance of construction contracts within and outside Iowa.**

**219.5(1)** The use of building materials, supplies, or equipment in the performance of construction contracts by the manufacturer outside Iowa is not a sale of tangible personal property and, therefore, is not a taxable event. The use of tangible personal property as building materials, supplies, or equipment by the manufacturer in the performance of construction contracts in Iowa is a sale at retail and a taxable event. The tax is computed on the manufacturer's fabricated cost or cost of production. See rule 701—219.6(423) for a characterization of the term manufacturer's "fabricated cost."

**219.5(2)** A contractor-retailer's withdrawal of materials from inventory for use in construction contracts outside this state is not a taxable event.

**219.5(3)** A contractor is a consumer by statute. A contractor's purchase of materials for use in a construction contract is subject to tax whether the materials are purchased for use in construction contracts performed in Iowa or outside this state.

**219.5(4)** A manufacturer's purchase of tangible personal property consumed as building material in the manufacturer's or the manufacturer's subcontractor's performance of construction contracts within Iowa is taxable. The tax is computed on the fabricated cost or cost of production of the materials. See rule 701—219.6(423) for a characterization of the term "fabricated cost." The purchase of tangible personal property consumed by a manufacturer as building material in the manufacturer's or the manufacturer's subcontractor's performance of a construction contract outside Iowa is not subject to tax.

**219.5(5)** Reference rule 701—32.8(423) for an exemption from use tax for building materials, supplies, or equipment purchased outside Iowa, brought into this state, and subsequently used in the performance of a construction contract outside this state.

**701—219.6(423) Tangible personal property used or consumed by the manufacturer thereof.** When a person who is primarily engaged in the manufacture of building materials, supplies, or equipment for sale and not for the person's own use or consumption, considering the totality of the business, from time to time uses or consumes the building materials, supplies, or equipment for construction purposes, the person is deemed to be making retail sales to one's self and subject to tax on the basis of the fabricated cost of the items so used or consumed for construction purposes. If equipment, building materials, or supplies are used by a manufacturer in the performance of a construction contract, a "sale" occurs only if the equipment, materials, or supplies are used in the performance of a construction contract in Iowa. For purposes of this rule, the term "fabricated cost" means and includes the cost of all materials as well as the cost of labor, power, transportation to the plant, and other plant expenses but not installation on the job site. *Associated General Contractors of Iowa v. State Tax Commission*, 255 Iowa 673, 123 N.W.2d 922 (1963). Also see rule 701—219.4(423) relating to contractors and rule 701—219.5(423) relating to materials, supplies, and equipment used in construction contracts within and outside Iowa.

**701—219.7(423) Prefabricated structures.**

**219.7(1) Basic concepts and general rules.** A "prefabricated structure" is any structure assembled in a factory and capable of transport to the location where it will be used in the performance of a construction contract by placement on a foundation either by the buyer or a designated contractor. The term "prefabricated structure" includes a "modular home" as defined in rule 701—231.11(423), a mobile home whether or not sold subject to the issuance of a certificate of title, "manufactured housing" (reference definition in rule 701—33.10(423)), sectionalized housing, precut housing packages, and panelized construction. With a few major exceptions (see subrule 219.7(2) regarding the "60 percent rule" and reference rule 701—33.10(423) regarding the taxation of manufactured housing while it is real property), the sales and use tax treatment of prefabricated structures generally follows the treatment of construction materials, that is, tax is due when those structures are sold to or used by owners,

contractors, subcontractors, or builders. Sales of prefabricated structures which have not been erected on a foundation are considered sales of tangible personal property and thus are taxable at the time of retail sale. The usual basis for computing sales or use tax is the purchase price charged to a consumer or user by the seller of a prefabricated structure. *Custom Built Homes Co. v. Kansas State Commission of Revenue and Taxation*, 184 Kan. 31, 334 P.2d 808 (1959). Sales or use tax is due on the full purchase price when a prefabricated structure is delivered under a contract for sale or sold for use in Iowa. *Dodgen Industries Inc. v. Iowa State Tax Commission*, 160 N.W.2d 289 (Iowa 1968).

**219.7(2)** *Exceptions to the general rules.* There are a number of exceptions to the general rules stated above in 219.7(1). Those exceptions are applicable to modular and mobile homes and manufactured housing. They are explained as follows:

*a. Modular homes.* Only 60 percent of the sales price from the sale of a modular home is subject to Iowa tax. See rule 701—231.11(423). This 60 percent rule is applicable only to a “modular home” as that phrase is defined in rule 701—231.11(423) and not to other types of prefabricated structures which do not meet the definition of the term “modular home” such as sectionalized housing or panelized construction. Also, the 60 percent rule is not applicable to the sale of materials used in the assembly of a modular home, only to the sale of the finished product.

*b. Mobile homes and manufactured housing.* Iowa use tax and not Iowa sales tax is imposed on mobile homes or manufactured housing sold subject to the issuance of a certificate of title, and, similar to 219.7(2) “a” above, use tax is imposed only upon 60 percent of the purchase price of these mobile homes or manufactured housing. Reference rule 701—32.3(423). All mobile homes sold in Iowa or sold outside Iowa for use in this state are sold subject to Iowa use tax, whether sold for placement within or outside a mobile home park; see 2005 Iowa Code chapter 423 and Iowa Code chapter 435.

**219.7(3)** *Tax consequences of sales of modular homes by various parties, some operating in a dual capacity.*

*a.* A retailer (dealer) that is not additionally a contractor or manufacturer of modular homes purchases those homes tax-free from a wholesaler or manufacturer for subsequent resale to contractors or owners. Tax must be collected when the dealer sells the modular home to an owner or contractor.

*b.* A contractor that is not a dealer must pay tax when purchasing a modular home for use in a construction contract or for some other purpose. A contractor’s sale of a modular home to an owner or another contractor is treated as explained in Examples 2 and 4 of rule 701—219.4(423).

*c.* A dealer that is also a contractor will purchase homes tax-free for inclusion in its inventory. Tax is imposed when the dealer withdraws a home from inventory for sale or use in the performance of a construction contract as explained in rule 701—219.4(423).

*d.* A manufacturer that acts as its own dealer and sells its own modular homes at retail to contractors or owners will collect tax on the sales price from its sales of those modular homes to its customers. This situation is in contrast to that described in subrule 701—219.7(4) in which a manufacturer uses its own modular homes in the performance of construction contracts and the tax due is computed on a sum other than the sales price from the sale of a home.

What is stated in this subrule concerning sales of modular homes is generally applicable to the use tax on mobile homes and manufactured housing. However, one distinct difference is that mobile homes and manufactured housing are seldom, if ever, purchased by a dealer for any subsequent use in the performance of construction contracts. A dealer will often purchase a mobile home or manufactured housing for subsequent resale to a customer as tangible personal property and then will place or install the mobile home or manufactured housing on a site prepared by the customer. This is not the performance of a construction contract (see rule 701—219.8(423)), and the dealer is a retailer who installs tangible personal property and is not a construction contractor.

**219.7(4)** *Manufacturers who perform construction contracts.* When companies whose principal business is the manufacture of prefabricated structures use those structures in the performance of construction contracts, this use is treated as a retail sale of the structures on the manufacturer’s part. See rule 701—219.6(423) for a detailed description of the sales tax treatment of this sort of transaction. The 60 percent rule (see 219.7(2) above) is not applicable when calculating the amount of tax owed by a manufacturer.

**219.7(5) Examples.** The following examples are intended to illustrate who must collect or remit sales or use tax when a manufacturer sells a modular home to a contractor or owner or acts as a contractor in erecting the home. The incidence of tax depends on several factors, such as the nature of the manufacturer's business, the point of delivery, the contractual agreement for erection and whether or not a sale for resale has occurred.

EXAMPLE 1. The manufacturer is located outside Iowa. The manufacturer contracts with an Iowa customer to build a home in the manufacturer's factory. The manufacturer also contracts to completely erect the home, install the furnace, and do electrical and other necessary work to make the home ready for occupancy. The main source of the manufacturer's income relates to on-site construction. The manufacturer has paid a sales tax equal to Iowa tax in its state of residency. The manufacturer would be considered to be performing a construction contract in Iowa and would owe use tax in Iowa; however, a sales tax credit would be allowed for tax paid to the other state.

EXAMPLE 2. The manufacturer is located outside Iowa. An Iowa unrelated builder/dealer contracts with the customer for the home and then contracts with the manufacturer for construction, delivery, and installation on the customer's foundation. The manufacturer delivers the home into Iowa on the manufacturer's own truck. The customer, by contractual agreement, is obligated to pay for the home on delivery of the property, so the sale takes place in Iowa. In this situation, the manufacturer is involved in the sale of tangible personal property rather than the sale of real estate and must collect Iowa sales tax on 60 percent of the sales price to the Iowa builder/dealer.

EXAMPLE 3. The manufacturer is located outside Iowa. The manufacturer contracts to sell a home to a customer (owner) in Iowa. The manufacturer hires a common carrier to deliver the home to the Iowa customer. The manufacturer has no activity in Iowa that would create a "nexus" requiring the manufacturer to collect Iowa tax. In this situation, the Iowa customer is required to remit use tax on 60 percent of the purchase price of the home.

EXAMPLE 4. The manufacturer may be located in Iowa or outside Iowa. The manufacturer sells a home to a dealer in Iowa that will resell the home to the final customer. The manufacturer may deliver the home, or delivery may be made by a common carrier. The manufacturer has no contractual obligation for erection. In this situation, the manufacturer is making a sale for resale and is not required to collect tax. The manufacturer must have a valid resale certificate on file from the dealer. The dealer, if in Iowa, would be required to collect tax when the home is sold.

EXAMPLE 5. The manufacturer is located in Iowa. The manufacturer contracts to furnish, deliver, and perform the setup on a home in a state other than Iowa. The manufacturer withdraws the home from inventory and transports the home to the other state for setup. In this situation, the Iowa manufacturer does not owe any Iowa tax because 2005 Iowa Code subsection 423.2(1) "b" exempts building materials and supplies that manufacturers withdraw from inventory for construction outside Iowa.

EXAMPLE 6. The manufacturer is located in Iowa. The manufacturer sells a home to an Iowa customer and agrees, under separate contract, to transport the home to the job site and perform the setup. The manufacturer should collect tax on 60 percent of the sales price of the home. The customer also wants a garage. The manufacturer agrees to sell the lumber, nails, and shingles to the customer who would build the garage. This sale would be considered a sale at retail, and the manufacturer should collect tax on the entire sales price of these materials. The same would be true if the manufacturer sold appliances separate from the sale of the home; sales tax would be due on the entire sales price of the appliances.

EXAMPLE 7. The manufacturer may be located inside or outside Iowa. The manufacturer sells a modular home to a dealer that is a general contractor. The dealer subcontracts the work of placing the home on a foundation to various third parties, which transport the home to its site, excavate for and pour the concrete slab, and perform plumbing, electrical hookup, and all other services which are part of the construction contract for placing the modular home at its location. Since the sale of the modular home is to a dealer that is a contractor, the manufacturer will collect and the dealer will pay tax on 60 percent of the modular home's invoice price.

**701—219.8(423) Types of construction contracts.** The term “construction contract” is defined as an agreement under the terms of which an individual, corporation, partnership or other entity agrees to furnish the necessary building or structural materials, supplies, equipment or fixtures and to erect the same on the project site for a second party known as a sponsor. Nonexclusive examples of the types of construction contracts include: lump-sum contracts; cost plus contracts; time and material contracts; unit price contracts; guaranteed maximum or upset price contracts; construction management contracts; design built contracts; and turnkey contracts.

The following is a nonexclusive list of activities and items which could fall within the meaning of a construction contract or are generally associated with new construction, reconstruction, alteration, or expansion of a building or structure. The list is provided merely for the purpose of illustration. It should not be used to distinguish machinery and equipment from real property or structures since such a determination is factual. See rules 701—219.11(423) and 701—219.12(423) for details.

- Ash removal equipment (installed as distinguished from portable units)
- Automatic sprinkler systems (fire protection)
- Awnings and venetian blinds which become attached to real property
- Boilers (installed as distinguished from portable units)
- Brick work
- Builder’s hardware
- Burglar alarm and fire alarm fixtures
- Caulking materials work
- Cement work
- Central air conditioner installation
- Coal handling equipment (installed as distinguished from portable units)
- Concrete work
- Counters, lockers (installed as distinguished from portable units), and prefabricated cabinets
- Drapery installation
- Electric conduit work and items relating thereto
- Electric distribution lines
- Electric transmission lines
- Floor covering which is permanently installed—see rule 701—16.48(422,423) for an exception to this regarding carpeting
- Flooring work
- Furnaces, heating boilers and heating units
- Glass and glazing work
- Gravel work (excluding landscaping)
- Installation of modular homes on foundations
- Lathing work
- Lead work
- Lighting fixtures
- Lime work
- Lumber and carpenter works
- Macadam work
- Millwork installation
- Mortar work
- Oil work
- Paint booths and spray booths (installed as distinguished from portable units)
- Painting work
- Paneling work
- Papering work
- Passenger and freight elevators
- Piping valves and pipe fitting work
- Plastering work

- Plumbing work
- Prefabricated cabinets, counters, and lockers (installed as opposed to portable units)
- Putty work
- Refrigeration units (central plants installation as distinguished from portable units)
- Reinforcing mesh work
- Road construction (concrete, bituminous, gravel, etc.)
- Roofing work
- Sheet metal work
- Sign installation (other than portable sign installation)
- Steel work
- Stone work
- Stucco work
- Tile work—ceiling, floor and walls
- Underground gas mains
- Underground sewage disposal
- Underground water mains
- Vault doors and equipment
- Wallboard work
- Wall coping work
- Wallpaper work
- Water heater and softener installation
- Weather stripping work
- Wire net screen work
- Wood preserving work

**701—219.9(423) Machinery and equipment sales contracts with installation.** Machinery and equipment sales contracts with installation are transactions which are considered a sale of tangible personal property to a final consumer. Therefore, the individual who sells the equipment with installation must purchase the machinery and equipment tax-free as a purchase for resale. This rule should not be confused with subrule 219.3(3) regarding building equipment. The contract should itemize the sales tax separately. If a contractor wishes to avoid an itemization of sales and use tax on machinery and equipment which remains tangible personal property, the contractor can do so by figuring the tax as a general overhead expense and including a statement in the contract and related invoices that “sales tax is included in the contract price.”

If the sales transaction is one completed out of state and shipped in interstate commerce to a consumer or a user in Iowa, and not otherwise exempt from tax, the final purchaser is required to pay Iowa use tax on the purchase price of the machinery and equipment.

In a “mixed contract” (a construction contract mingled with a machinery and equipment sales contract), the elements of the contract should be separated for sales tax purposes. See rule 701—219.10(423).

Certain services which are enumerated in 2005 Iowa Code section 423.2 are subject to tax when performed under a contract for the installation of machinery and equipment which is not done in connection with new construction, reconstruction, alteration, expansion or remodeling of a building or structure. Reference rule 701—15.14(422,423) relating to installation charges. Examples of the enumerated services are: electrical installation; plumbing; welding; and pipe fitting. Other labor charges for job site installation which do not involve a taxable enumerated service are not subject to tax if the charges are separately contracted or, if no written contract exists, are separately itemized on the billing from the seller to the purchaser.

**EXAMPLE.** Company B contracts with Company A to furnish and install a portable conveyor unit in Company A’s new building. Company B can purchase the portable conveyor unit tax-free because the portable conveyor unit maintains its identity as tangible personal property after installation and does not become a component part of the real property. Company B would then charge tax to Company A on

the sale of the portable conveyor unit. Installation charges would be part of the total sales price subject to tax unless they are separately contracted or, if no written contract exists, separately itemized on the billing from Company B to Company A.

**701—219.10(423) Construction contracts with equipment sales (mixed contracts).** Construction contracts with equipment sales, commonly known as mixed contracts, place a dual burden on the contractor, as a contractor is a consumer of construction materials and also a retailer of the machinery and equipment. As a consumer by statute of construction building materials, supplies, and building equipment, a contractor is required to pay sales tax to the supplier at the time of purchase or remit use tax to the department if purchasing building materials, supplies, and building equipment from an out-of-state supplier. Reference 701—Chapter 30 of the rules regarding use taxes. Machinery and equipment must be purchased for resale by the contractor if the machinery and equipment does not become real property. This means that the contractor does not pay tax to a supplier at the time of purchase of machinery and equipment, but instead, the contractor is responsible for collecting sales tax on the sales price from a sponsor and remitting it to the department.

EXAMPLE. Company A contracts with Company B to have Company B build a new building and install all of the production machinery and equipment for the new building. Company B must pay tax on its purchases of building materials and supplies which lose their identity as tangible personal property and become a component part of the real property. Company B also purchases some refrigeration units for the new building which maintain their identity as tangible personal property. These units must be purchased tax-free by Company B because they will be resold. Company B would then charge Company A the tax on the units which retain their identity as tangible personal property. The installation charges for the units which remain as tangible personal property would be part of the total sales price subject to tax unless they are separately contracted or, if no written contract exists, are separately itemized on the billing from Company B to Company A.

When a mixed construction contract is let for a lump-sum amount, the machinery and equipment furnished and installed shall be considered, for the purposes of this rule only, as being sold by the contractor for an amount equal to the cost of the machinery and equipment.

Persons required to collect sales tax in Iowa under machinery and equipment contracts or a mixed contract are required to have a sales tax or a retailer's use tax permit.

**701—219.11(423) Distinguishing machinery and equipment from real property.** A construction contract may include many activities, but it does not include a contract for the sale and installation of machinery or equipment. Machinery and equipment includes property that is tangible personal property when it is purchased and remains tangible personal property after installation. Generally, tangible personal property can be moved without causing damage or injury to itself or to the structure, it does not bear the weight of the structure, and it does not in any other manner constitute an integral part of a structure. For exemptions related to the sale of computers, machinery, and equipment if the sale occurs as part of a contract entered into on or after July 1, 2016, see rules 701—230.14(423) to 701—230.22(423).

**219.11(1)** The following is a list of property that, under normal conditions, remains tangible personal property after installation. The list is nonexclusive and is offered for illustrative purposes only:

*a.* Furniture, radio and television sets and antennas, washers and dryers, portable lamps, home freezers, portable appliances and window air-conditioning units.

*b.* Portable items such as casework, tables, counters, cabinets, lockers, athletic and gymnasium equipment, and other related easily movable property attached to the structure.

*c.* Machinery, equipment, tools, appliances, and materials used exclusively as such by manufacturers, industrial processors and others performing a processing function with the items, including:

(1) Computers, machinery, and equipment directly and primarily used in processing by a manufacturer (see rule 701—230.15(423)).

(2) Computers, machinery, and equipment directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, machinery, and equipment used in processing by a manufacturer (see rule 701—230.16(423)).

(3) Computers, machinery, and equipment directly and primarily used in research and development of new products or processes of processing (see rule 701—230.17(423)).

(4) Computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise (see rule 701—230.18(423)).

(5) Computers, machinery, and equipment directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).

(6) Pollution-control equipment used by a manufacturer, including but not limited to that required or certified by an agency of Iowa or the United States government (see rule 701—230.20(423)).

*d.* Office, bank, and savings and loan association furniture and equipment, including office machines.

*e.* Radio, television, and cable television station equipment, but not broadcasting towers.

*f.* Certain equipment used by restaurants and in institutional kitchens; for instance, dishwashers, stainless steel wall cabinets, stainless steel natural gas stoves, stainless steel natural gas convection ovens, and combination ovens and steamers with stands. This paragraph is not applicable to similar items used in residential kitchens. See Petition of Taylor Industries Inc. (Dkt No. 94-30-6-0367, 3-14-95).

**219.11(2)** The following is a list of property that, under normal conditions, becomes a part of realty. The list is nonexclusive and is offered for illustrative purposes only:

*a.* Boilers and furnaces.

*b.* Built-in household items such as kitchen cabinets, dishwashers, sinks (including faucets), fans, garbage disposals, and incinerators.

*c.* Buildings, and structural and other improvements to buildings, including awnings, canopies, foundations for machinery, floors (including computer room floors), walls, general wiring and lighting facilities, roofs, stairways, stair lifts, sprinkler systems, storm doors and windows, door controls, air curtains, loading platforms, central air-conditioning units, building elevators, sanitation and plumbing systems, decks, and heating, cooling and ventilation systems.

*d.* Fixed (year-round) wharves and docks.

*e.* Improvements to land including patios, retaining walls, roads, walks, bridges, fencing, railway switch tracks, ponds, dams, ditches, wells, underground irrigation systems, drainage, storm and sanitary sewers, and water supply lines for drinking water, sanitary purposes, and fire protection. See rule 701—226.10(423) relating to drainage tile.

*f.* Mobile and modular homes installed on foundations.

*g.* Planted nursery stock.

*h.* Residential water heaters, water softeners, intercoms, garage door opening equipment, pneumatic tube systems, and music and sound equipment (except portable equipment).

*i.* Safe deposit boxes, drive-up and walk-up windows, night depository equipment, remote TV auto teller systems, vault doors, and camera security equipment (except portable equipment).

*j.* Seating in auditoriums and theaters and theater stage lights (except portable seating and lighting).

*k.* Swimming pools (wholly or partially underground (except portable pools)).

*l.* Truck platform scale foundations.

*m.* Walk-in cold storage units that become a component part of a building.

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—219.12(423) Tangible personal property that becomes structures.** Items that are manufactured as tangible personal property can, by their nature, become structures. However, the determination is factual and must be made on an item-by-item basis. For exemptions related to the sale of computers, machinery, and equipment occurring as part of a contract entered into on or after July 1, 2016, see rules

701—230.14(423) to 701—230.22(423). The following is a listing of criteria that courts have used in making such a determination:

1. The degree of architectural and engineering skills necessary to design and construct the structure.
2. The overall scope of the business and the contractual obligations of the person designing and building the structure.
3. The amount and variety of materials needed to complete the structure, including the identity of materials prior to assembly and the complexity of assembly.
4. The size and weight of the structure.
5. The permanency or degree of annexation of the structure to other real property which would affect its mobility.
6. The cost of building, moving or dismantling the structure.
7. For property sold as part of a contract entered into on or after July 1, 2016, computers, machinery, or equipment used for an exempt purpose under Iowa Code section 423.3(47) remains tangible personal property. See rules 701—230.14(423) to 701—230.22(423).

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—219.13(423) Tax on enumerated services.** The tax on the services enumerated in 2005 Iowa Code section 423.2 is basically a tax on labor. When such services are performed on or connected with new construction, reconstruction, alteration, expansion or remodeling of real property or structures, the services are exempt from tax. Neither the repair nor the rental of machinery on the job site is exempt from tax under this rule. See rule 701—219.21(423) for an explanation of the exemption in favor of rented machinery used by a contractor on a job site.

The distinction between a repair (see subrule 219.13(1)) and new construction, reconstruction, alteration, expansion and remodeling activities (see subrule 219.13(2)) can, oftentimes, be difficult to grasp. Therefore, the intent of the parties and the scope of the project may become the factors which determine whether certain enumerated services are taxable. An area of particular difficulty is the distinction between repair and remodeling. Remodeling a building or other structure means much more than making repairs or minor changes to it. Remodeling is a reforming or reshaping of a structure or some substantial portion of it to the extent that the remodeled structure or portion of the structure is in large part the equivalent of a new structure or part thereof. See *Board of Commissioners of Guadalupe County v. State*, 43 N.M. 409, 94 P.2d 515 (1939) and *City of Mayville v. Rosing*, 19 N.D. 98, 123 N.W. 393 (1909).

**219.13(1)** Repair is synonymous with mend, restore, maintain, replace and service. A repair contemplates an existing structure or tangible personal property which has become imperfect and constitutes the restoration to a good and sound condition. A repair is not a capital improvement; that is, it does not materially add to the value or substantially prolong the useful life of the property.

2005 Iowa Code section 423.1(42) defines a person engaged in the business of performing taxable services as a retailer. Since retailers may purchase building materials, supplies and equipment for resale, persons making taxable repairs (repairpersons and servicepersons) are not considered to be contractors and are not subject to the provisions of 2005 Iowa Code subsection 423.2(1)“b.” In addition, such persons are not considered to be owners, subcontractors or builders. Repairpersons and servicepersons will normally purchase building materials and supplies free of tax for subsequent resale to their customers; contractor-retailers will also do this. However, contractors, subcontractors or builders who may make repairs are subject to 2005 Iowa Code subsection 423.2(1)“b” and must pay tax at the time building materials, supplies and equipment are purchased from vendors even though the contractors, subcontractors or builders hold a valid sales tax permit. See rules 701—219.2(423) and 701—219.3(423). In determining who is a contractor and who is a retailer of repair services, the department looks to the total business of the entity in question and not to any one portion of it. Thus, the fact that a business whose overall activity is contracting has a division engaged in taxable repair services does not transform that business into a retailer providing services rather than a contractor. When contractors do repair work, they may separately itemize labor and materials charges and collect

sales tax on all charges. A contractor's markup on a materials charge is part of any taxable sale. A contractor can take a credit for any tax paid on the purchase of materials that are sold as part of a service transaction.

When other persons making repairs sell tangible personal property at retail in connection with any taxable service enumerated in 2005 Iowa Code section 423.2, those persons shall collect and remit tax on the sales price. The person making repairs shall purchase tangible personal property for resale when the property is used in the repair job and is resold to a customer. Reference rule 701—18.31(422,423) for an explanation of when persons performing services sell the property that the persons use in performing those services to their customers. Nonexclusive examples of repair situations are as follows:

- a. Repair of broken or defective glass.
- b. Replacement of broken, defective or rotten windows.
- c. Replacing individual or damaged roof shingles.
- d. Replacing or repairing a segment of worn-out or broken kitchen cabinets.
- e. Repair or replacement of broken or damaged garage doors or garage door openers.
- f. Replacing or repairing a part of a broken or worn tub, shower, or faucets.
- g. Replacing or repairing a broken water heater, furnace or central air conditioning compressor.
- h. Restoration of original wiring in a house or building.

**219.13(2)** The following are examples of new construction, reconstruction, alteration, expansion and remodeling activities:

- a. The building of a garage or adding a garage to an existing building would be considered new construction.
- b. Adding a redwood deck to an existing structure would be considered new construction.
- c. Replacing a complete roof on an existing structure would be considered reconstruction or alteration.
- d. Adding a new room to an existing building would be considered new construction.
- e. Adding a new room by building interior walls would be considered alteration.
- f. Replacing kitchen cabinets with some modification would be considered an improvement.
- g. Paneling existing walls would be considered an improvement.
- h. Laying a new floor over an existing floor would be considered an improvement.
- i. Rebuilding a structure damaged by flood, fire or other uncontrollable disaster or casualty would be considered reconstruction.
- j. Building a new wing to an existing building would be considered an expansion.
- k. Rearranging the interior physical structure of a building would be considered remodeling.
- l. Installing manufactured housing or a modular or mobile home on a foundation would be considered new construction. However, reference rule 701—33.10(423) for a description of the special treatment of taxable installation charges when the taxable sale of manufactured housing as real estate occurs.
- m. Replacing an entire water heater, water softener, furnace or central air conditioning unit.
- n. Sign installation and well-drilling services are generally performed in connection with new construction.

In all the examples, the contractor is responsible for paying tax to any supplier on materials. However, there would be no tax on any enumerated services.

**219.13(3)** "*On or connected with.*" The term "on or connected with" is broad and should be used to convey generally accepted meaning. Therefore, in a specific situation, the facts relating thereto are controlling in determining whether the exemption is applicable. "On or connected with" does not connote that those things connected have to be primary or subsidiary to the construction, reconstruction, alteration, expansion or remodeling of the real property.

a. *Incidental relationship.* An incidental relationship can qualify the activity for exemption if the relationship forms an intimate connection with the construction activity. For example, the service of excavating and grading relating to the clearing of land to begin construction of a building would qualify for the exemption; however, excavating and grading land without motive toward construction would not

qualify for exemption even though at some later date plans to construct a building were created and a structure was actually erected.

*b. Proximity in time.* The presence of a time relationship can also be a factor in determining the applicability of exemption. For example, tax would not apply to separate labor charges relating to the installation of institutional kitchen equipment in a building while remodeling of the real property was in progress. (Tax could apply to the sales price of the institutional kitchen equipment; see rule 701—230.14(423)). However, if a year after all construction activity has ended, the owner decides to install a piece of institutional kitchen equipment in the building, any taxable enumerated services relating thereto would be subject to tax. Further, if, following construction, the land is graded for the purpose of seeding a new lawn, the exemption would be applicable. However, if the lawn does not grow and the land is regraded the following year, the exemption would not be applicable. Therefore, the motive behind the activity and the course of events that could reasonably be expected to occur would be a further consideration in determining if the exemption is applicable.

*c. Physical proximity.* A physical relationship is also a factor that should be evaluated. If a building is constructed to house machinery, any enumerated services relating to the installation of that machinery would be exempt from tax. For example, piping joining two pieces of equipment housed in separate buildings would qualify for exemption if the equipment in either building was installed while such new construction, reconstruction, alteration, expansion or remodeling to the structure was also taking place to house the equipment.

*d. Totality of the facts and circumstances.* An incidental relationship, a time relationship, and close physical proximity may not be enough to support the conclusion that a taxable service is performed in connection with new construction or reconstruction. For example, a homeowner hires a general contractor to add a new room to an existing home (which is new construction; see 219.13(2) “d”). The existing home is in need of a number of the repairs described in subrule 219.13(1); for example, it is in need of rewiring and replacement of a broken window. The general contractor rewires the home and repairs the window in addition to building the new room. The taxable services which the general contractor performs while rewiring the home and repairing the window are not performed in connection with the construction of the new room simply because those services happen to be performed at the same time and on the same home as the new construction. If the addition of the new room were the cause of the need for the taxable service (e.g., the window was broken during construction of the new room) and not just a convenient occasion for performance of the service, that performance would be exempt from tax. The facts and motives are important in the determination of the taxability of services relating to construction activities. However, it should also be noted that taxes on enumerated services are applicable to repair or installation work that is not a construction activity. See subrule 219.13(1) relating to persons who make repairs or perform enumerated services for more information.

**219.13(4)** Excavating includes digging, hollowing out, scooping out, or making a hole in the earth. It also includes removal of materials or substance found beneath the surface. Grading includes a change in the earth’s structure by scraping and filling to a common level or a fixed line known as a grade. The enumerated services of excavating and grading are not subject to tax if performed on or connected with new construction. Removal of overburden which is directly related to road building, building of dikes, building of farm ponds, and creating drainage ditches would not be taxable as such activities would be considered on or connected with the creation of a structure. See *Maasdam v. Kirkpatrick*, 214 Iowa 1388 (1932). However, the mere removal of overburden, without more, would be taxable as the enumerated service of excavating or grading under 2005 Iowa Code subsection 423.2(6).

**219.13(5)** Services associated with new construction or reconstruction, for example, which are not taxable include, but are not limited to, brick laying, concrete finishing, tiling, siding installation, laying of linoleum and other flooring and carpet installation. No tax can be collected on the performance of these services even when they are furnished in connection with the performance of repairs.

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—219.14(423) Transportation cost.** Transportation charges and delivery charges are not subject to the Iowa sales and use tax when they are separately contracted or, if no written contract exists, are separately itemized on the billing from the seller to the purchaser. Reference rule 701—15.13(422,423).

**701—219.15(423) Start-up charges.** Start-up charges are not subject to the Iowa sales and use tax when they are separately contracted or, if no written contract exists, are separately itemized on the billing from the seller to the purchaser.

**701—219.16(423) Liability of subcontractors.** A subcontractor who is providing materials and labor on the actual construction of the building or structure has the same status and tax responsibilities as a general contractor under the Iowa statutes. However, where an individual or firm is hired to provide machinery and equipment to a general contractor or another subcontractor, the individual or firm is considered a material supplier rather than a subcontractor. This is true even though the machinery and equipment are supplied with installation. Items of machinery and equipment sold by material suppliers to contractors shall be sold for resale and the contractor must provide the material supplier with a valid resale certificate.

**701—219.17(423) Liability of sponsors.** The sponsor cannot be held responsible for a tax liability incurred on building materials, supplies and equipment by a general contractor or subcontractor in the completion of a construction contract. Likewise, a general contractor cannot be held responsible for the tax liability incurred on building materials, supplies and equipment by a subcontractor in the completion of a construction contract. The tax responsibility regarding machinery and equipment contracts depends on where the sale was consummated. If the sale was consummated in Iowa, the seller is responsible for the collection and remittance of tax unless a valid exemption certificate is given by the purchaser. If the sale was consummated outside Iowa and the seller does not remit use tax to the department, then a use tax would be due from the Iowa user.

**701—219.18(423) Withholding.** A sponsor of a contract with a nonregistered out-of-state (nonresident) contractor may be asked to withhold the final payment of the contract as a guarantee that sales and use taxes will be paid. The withholding requirement may also apply to registered out-of-state contractors at the discretion of the department. The department will issue a notice to the sponsor to support the withholding of funds. In order to seek a release of the notice, the out-of-state contractor is required to file a report with the department consisting of the following departmental forms:

1. Form 35-012, which is a listing of subcontractors to whom the out-of-state contractor has awarded a construction contract. This statement should be submitted on each project as it becomes available.

2. Form 35-013, which is a list of material suppliers both in state and out of state from whom tangible personal property has been purchased for use in completing each project or contract.

3. Form 35-001, which is a summary of the provisions of the actual contract.

All letters of release furnished by the department are subject to audit and, therefore, are not unconditional release from any Iowa sales or use tax liability. All letters of release will be issued within 60 days upon receipt of the proper information unless an error or discrepancy is noted.

**701—219.19(423) Resale certificates.** Whenever machinery and equipment which will remain tangible personal property after installation is purchased for a machinery and equipment contract by a contractor from a supplier or a material supplier, it should be purchased for resale. See rule 701—219.9(423). Resale purchases are most commonly related to machinery and equipment sales contracts with installation and mixed construction contracts. Contractor-retailers and persons making repairs may also purchase materials for resale as long as they collect tax on their retail sales and pay the tax themselves on items withdrawn from inventory for use in the performance of a construction contract. See rule 701—219.4(423) and subrule 219.13(1). Resale certificates can be obtained by contacting the Iowa department of revenue. Reference rule 701—15.3(422,423) for detailed information on resale certificates.

**701—219.20(423) Reporting for use tax.** An Iowa contractor can report use tax either on a consumer's use tax return or as consumed goods on a sales tax return. Tax is due in the quarter the materials are delivered into Iowa. Nonresident contractors should report use tax on a consumer's use tax return. Consumer's use tax returns for nonresident contractors must be obtained directly from the department of revenue unless the contractor is registered with the department.

**701—219.21(423) Exempt sale, lease, or rental of equipment used by contractors, subcontractors, or builders.**

**219.21(1) Exempt lease or rental of machinery and equipment.** On and after July 1, 2004, the sales price on the lease or rental only of the following types of machinery and equipment is exempt from tax: all machinery, equipment, and replacement parts directly and primarily used by contractors, subcontractors, and builders for new construction, reconstruction, alterations, expansion, or remodeling of real property or structures and all machinery, equipment, and replacement parts which improve the performance, safety, operation, or efficiency of the equipment and replacement parts so used. A contractor's, subcontractor's, or builder's purchases of this equipment would continue to be taxable, as would a lessor's purchases of machinery, equipment, or replacement parts for subsequent exempt rental to a contractor, subcontractor, or builder. Reference rule 701—26.18(422,423) for an extensive explanation of this matter.

**219.21(2) Exempt sales, including lease or rental of equipment.** Beginning July 1, 2005, the sales price on the sale in any form, including lease or rental, of the following types of equipment is exempt from the tax imposed by Iowa Code chapter 423: self-propelled building equipment, self-constructed cranes, pile drivers, structural concrete forms, regular and motorized scaffolding, generators, or attachments customarily drawn or attached to those items of equipment, including auxiliary attachments which improve the performance, safety, operation, or efficiency of the equipment and replacement parts and are directly and primarily used by contractors, subcontractors, and builders for new construction, reconstruction, alterations, expansion, or remodeling of real property or structures. The sales price from a sale in a form other than that of a lease or rental is not exempt from all excise tax. See 701—Chapter 241, division II, for an explanation of the new excise tax imposed on these transactions as of July 1, 2005.

These rules are intended to implement 2005 Iowa Code subsections 423.1(42), 423.2(1) "b" and "c," 423.2(6), 423.3(64), and 423.5(2) and 2005 Iowa Code Supplement subsections 423.3(37) and 423.3(85).

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CHAPTER 230  
EXEMPTIONS PRIMARILY BENEFITING MANUFACTURERS AND  
OTHER PERSONS ENGAGED IN PROCESSING

Rules in this chapter include cross references to provisions in 701—Chapters 15, 18 and 26 that were applicable prior to July 1, 2004.

**701—230.1** Reserved.

**701—230.2(423) Carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, and taxable services used in processing.** An expanded definition of “processing” is allowed to manufacturers of food products for human consumption using carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, and taxable services. For the purposes of this rule, the rental or leasing of tangible personal property is treated as the furnishing of a taxable service and not as the sale of tangible personal property.

**230.2(1)** “Manufacturer” characterized. A manufacturer is a person or entity different from a merchant, dealer, or retailer. See *Commonwealth v. Thackara Mfg. Co.*, 27 A. 13 (Pa. 1893). In order for a business to be a manufacturer, the principal business of that business must be manufacturing. See *Associated General Contractors v. State Tax Commission*, 123 N.W.2d 922 (Iowa 1963). Another distinction is that a merchant or retailer sells in order to earn a profit and a manufacturer sells to take profits already earned from prior activity. See *State v. Coastal Petrol Inc.*, 198 So. 610 (Ala. 1940). A person primarily engaged in selling tangible personal property in order to earn a profit and only incidentally engaged in creating products suitable for use from raw materials is not a manufacturer. A retail grocery store, incidentally and not primarily engaged in manufacturing activities such as meat cutting or production and packaging of baked goods, is not a “manufacturer of food products for human consumption” and is not entitled to claim the special processing exemption allowed to those manufacturers. Retail food stores, restaurants, and other persons incidentally engaged in food manufacturing activities can, however, continue to claim on their incidental processing activities the processing exemption allowed to persons who are not manufacturers of food products for human consumption. See rule 701—230.3(423).

**230.2(2)** The following activities constitute processing when performed by a manufacturer to create food products for human consumption. Any carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, or other taxable services primarily used in the performance of these activities is exempt from tax.

*a.* Treatment of material that changes its form, context, or condition in order to produce a marketable food product for human consumption. “Special treatment” of the material to change its form, context, or condition is not necessary to lawfully claim the exemption. Examples of “treatment” which would not be “special” are the following: the washing, sorting and grading of fruits or vegetables; the washing, sorting, and grading of eggs; and the mixing or agitation of liquids. By way of contrast, sterilization would be “special treatment.”

*b.* Maintenance of the quality or integrity of the food product and the maintenance or the changing of temperature levels necessary to avoid spoilage or to hold the food in marketable condition. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or other taxable service used in freezers, heaters, coolers, refrigerators, or evaporators used in cooling or heating which holds the food product at a temperature necessary to maintain quality or integrity or to avoid spoilage of the food or to hold the food product in marketable condition is exempt from tax. It is not necessary that the taxable service be used to raise or lower the temperature of the food. Also, processing of food products for human consumption does not cease when the food product is in marketable form. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used to maintain or to change a temperature necessary to keep the product marketable is exempt from tax.

*c.* Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or other taxable service primarily used in the maintenance of environmental conditions necessary for the safe or efficient use of machinery or material used to produce the food product is exempt from tax. For example, electricity used to air-condition a room in which meat is stored is exempt from tax if the purpose of the air conditioning is

to maintain the meat in a condition in which it is easy to slice rather than for the comfort of the employees who work in the room.

*d.* Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service primarily used in sanitation and quality control activities is exempt from tax. Nonexclusive examples exempt from tax include taxable services used in pH meters, microbiology counters and incubators used to test the purity or sanitary nature of a food product. For example, electricity used in egg-candling lights would be exempt from tax. Also, electricity, steam, or any taxable service used to power equipment which cleans and sterilizes food production equipment would be exempt from tax. Electricity used to power refrigerators used to store food samples for testing would be exempt from tax. Finally, electricity used to power “bug lights” or other insect-killing equipment used in areas where food products are manufactured or stored would be exempt from tax.

*e.* Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used in the formation of packaging for marketable food products for human consumption is exempt from tax. For example, electricity used in plastic bottle-forming machines by a food manufacturer is exempt from tax if the plastic bottles will be used to hold a marketable food product, such as milk. Any electricity, steam, or other taxable service used in the heating, compounding, liquefying and forming of plastic pellets into these plastic bottles is exempt.

*f.* Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used in placement of the food product into shipping containers is exempt from tax. For example, electricity used by a food manufacturer to place food products into packing cases, pallets, crates, shipping cases, or other similar receptacles is exempt.

*g.* Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used to move material which will become a marketable food product or used to move the marketable food product itself until shipment from the building of manufacture is exempt from tax. This includes, but is not limited to, taxable services used in pumps, conveyors, forklifts, and freight elevators moving the material or food product and taxable services used in door openers which open doors for forklifts or other devices moving the material or product. Any loading dock which is attached to a building of manufacture is a part of that building. Any electricity, steam, or taxable service used to move any food products to a loading dock is exempt from tax. If a food product is carried outside its building of manufacture by any conveyor belt system, electricity used by any portion of the system located outside the building is taxable.

This rule is intended to implement 2005 Iowa Code Supplement subsection 423.3(49).

**701—230.3(423) Services used in processing.** Electricity, steam, or any taxable service is used in processing only if the service is used in any operation which subjects raw material to some special treatment which changes, by artificial or natural means, the form, context, or condition of the raw material and results in a change of the raw material into marketable tangible personal property intended to be sold ultimately at retail. The following are nonexclusive examples of what would and would not be considered electricity, steam, or taxable services used in processing:

**230.3(1)** The sales price from the sale of electricity or steam consumed as power or used in the actual processing of tangible personal property intended to be sold ultimately at retail would be exempt from tax. The sales price is to be distinguished from that of electricity or steam consumed for the purpose of lighting, ventilating, or heating manufacturing plants, warehouses, or offices. The latter sales price would be taxable.

**230.3(2)** The sales price from electricity used in the freezing of tangible personal property, ultimately to be sold at retail, to make the property marketable would be exempt from sales tax. See *Fischer Artificial Ice & Cold Storage Co. v. Iowa State Tax Commission*, 81 N.W.2d 437 (Iowa 1957).

**230.3(3)** Electricity used merely in the refrigeration or the holding of tangible personal property for the purpose of preventing spoilage or to preserve the property in its present state would not be “used in processing” and, therefore, its sales price would be subject to tax. See *Fischer Artificial Ice, supra*.

Measurement of taxable and nontaxable use of electricity and steam. The exemption provided in the case of electricity or steam applies only upon the sales price from the sale of electricity or steam when

the energy is consumed as power or is used in the processing of food products or other tangible personal property intended to be sold ultimately at retail, as distinguished from electricity or steam which is consumed for taxable purposes. When practical, electricity or steam consumed as power or used directly in processing must be separately metered and separately billed by the supplier thereof to clearly distinguish energy so consumed from electricity or steam which is consumed for purposes or under conditions in which the exemption would not apply. If it is impractical to separately meter electricity or steam which is exempt from that electricity or steam upon which tax will apply, the purchaser must furnish an exemption certificate to the supplier with respect to what percentage of electricity or steam in the case of each purchaser is subject to the exemption. Reference 701—subrule 15.3(2). The exemption certificate must be supported by a study showing how the percentage was developed. When a certificate and study are accepted by the supplier as a basis for determining exemption, any changes in the processing method, changes in equipment or alterations in plant size or capacity affecting the percentage of exemption will necessitate the filing of a new and revised statement by the purchaser. When the electric or steam energy is separately metered, enabling the supplier to accurately apply the exemption in the case of processing energy, the purchaser need only file an exemption certificate since the supplier, under such conditions, will separately record and compute the consumption of energy which is exempt from tax apart from that energy which is subject to tax.

This rule is intended to implement Iowa Code section 423.3(49).

**701—230.4(423) Chemicals, solvents, sorbents, or reagents used in processing.** Chemicals, solvents, sorbents, and reagents directly used and consumed, dissipated, or depleted in processing tangible personal property intended to be sold ultimately at retail shall be exempt from sales and use tax. For the purpose of this processing exemption rule, free newspapers and shoppers' guides are considered to be retail sales. See 701—Chapter 211 for definition of the words "chemicals," "solvents," "sorbents," and "reagents."

For the purpose of this rule, a catalyst is considered to be a chemical, solvent, sorbent, or reagent. A catalyst is a substance which promotes or initiates a chemical reaction and, as such, is exempt from tax if consumed, dissipated, or depleted during processing of tangible personal property intended to be ultimately sold at retail.

To qualify for this exemption, all of the following conditions must be met:

1. The item must be a chemical, solvent, sorbent, or reagent.
2. The chemical, solvent, sorbent, or reagent must be directly used and consumed, dissipated, or depleted during processing as defined in referenced rule 701—18.29(422,423).
3. The processing must be performed on tangible personal property intended to be sold ultimately at retail.
4. The chemical, solvent, sorbent, or reagent need not become an integral or component part of the processed tangible personal property.

This rule is intended to implement Iowa Code section 423.3(50).

**701—230.5(423) Exempt sales of gases used in the manufacturing process.** Sales of argon and other similar gases to be used in the manufacturing process are exempt from tax. For the purposes of this rule, only inert gases are gases that are similar to argon. An "inert gas" is any gas that is normally chemically inactive. It will not support combustion and cannot be used as either a fuel or as an oxidizer. Argon, helium, neon, krypton, radon, and xenon are inert gases. Oxygen, hydrogen, and methane are nonexclusive examples of gases that are not inert. These sales are exempt only if the gas is purchased by a "manufacturer," for use in "processing," as those terms are defined in subrules 230.15(3) and 230.15(4).

This rule is intended to implement Iowa Code section 423.3(51).

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.6(423) Sale of electricity to water companies.** The sales price from the sale of electricity to water companies assessed for property tax pursuant to Iowa Code sections 428.24, 428.26, and 428.28, which is used solely for the purpose of pumping water from a river or well is exempt from sales tax. For

the purposes of this rule, “river” means a natural body of water or waterway that is commonly known as a river. “Well,” for the purposes of this rule, means an issue of water from the earth; a mineral spring; a pit or hole sunk into the earth to reach a water supply; a shaft or hole sunk to obtain oil, water, gas, etc.; or a shaft or excavation in the earth, in mining, from which run branches. *Pacific Gas and Electric Company v. Hufford*, 319 P.2d 1033, 1040 (Calif. 1957), citing Webster’s New International Dictionary, 2nd ed., unabridged.

This rule is intended to implement Iowa Code section 423.3(52).

**701—230.7(423) Wind energy conversion property.** The sales price from the sale of property used to convert wind energy to electrical energy or the sales price from the sale of materials used to manufacture, install, or construct property used to convert wind energy to electrical energy is exempt from tax.

For the purposes of this rule, “property used to convert wind energy to electrical energy” means any device which converts wind energy to usable electrical energy including, but not limited to, wind chargers, windmills, wind turbines, pad mount transformers, substations, power lines, and tower equipment.

This rule is intended to implement Iowa Code section 423.3(53).

**701—230.8(423) Exempt sales or rentals of core making and mold making equipment, and sand handling equipment.** This rule is applicable to the period beginning on or after July 1, 2004.

**230.8(1) Exempt sales and rentals of machinery and equipment.** The sales price from sales or rentals of core making, mold making, and sand handling machinery and equipment directly and primarily used by a foundry in the mold making process is exempt from tax. For the purposes of this rule, a “foundry” is an establishment where metal, but not plastic, is melted and poured into molds. A nonexclusive list of equipment which may be exempt under this rule includes sand storage tanks, conveyers, patterns, mallor controllers, and sand mixers. A nonexclusive list of items which would not be exempted by this rule includes sand and other materials (as opposed to equipment) used to build molds or cores, and supplies. Services used in the mold making process are not exempted from tax by this rule. For the purposes of this rule, core making, mold making, and sand handling equipment also include replacement parts necessary for the operation of the equipment which is used directly and primarily by a foundry in the mold making process. Reference 701—subrule 18.58(1) for definitions of “directly used,” “equipment,” “machinery,” “replacement part” and “supplies.”

**230.8(2) Exempt sales of fuel and electricity.** The sales price from sales of fuel used in creating heat, power, or steam for, or used for generating electric current for, or electric current sold for use in machinery or equipment the sale or rental of which is exempt under subrule 230.8(1) is exempt from tax.

**230.8(3) Exempt design and installation services.** The sales price from furnishing design and installation services, including electrical and electronic installation, of machinery and equipment the sale or rental of which is exempt under subrule 230.8(1) is exempt from tax. Reference rule 701—26.16(422) for characterizations of the words “installation” and “electronic installation.”

This rule is intended to implement Iowa Code section 423.3(82).

**701—230.9(423) Chemical compounds used to treat water.** Chemical compounds placed in water which is ultimately sold at retail should be purchased exempt from the tax. The chemical compounds become an integral part of property sold at retail. Chemical compounds placed in water which is directly used in processing are exempt from the tax, even if the water is consumed by the processor and not sold at retail.

Chemical compounds which are used to treat water that is not sold at retail or which are not used directly in processing shall be subject to tax. An example would be chlorine or other chemicals used to treat water for a swimming pool.

Special boiler compounds used by processors when live steam is injected into the mash or substance, whereby the steam liquefies and becomes an integral part of the product intended to be sold at retail and also becomes a part of the finished product, shall be exempt from tax.

This rule is intended to implement Iowa Code section 423.3(50).

**701—230.10(423) Exclusive web search portal business and its exemption.** Effective on or after July 1, 2007, a business that qualifies as a web search portal business that has a physical location in Iowa and that meets specific criteria may obtain an exemption from sales and use tax on specific purchases that are used in the operation and maintenance of the web search portal business. This exemption from sales and use tax also applies to the affiliates of a qualifying web search portal business.

**230.10(1) Definitions.** For the purpose of this exemption, the following definitions apply:

*a.* “Affiliate” means an entity that directly or indirectly controls, is controlled with or by, or is under common control with another entity.

*b.* “Control” means any of the following:

(1) In the case of a United States corporation, the ownership, directly or indirectly, of 50 percent or more of the voting power to elect directors.

(2) In the case of a foreign corporation, if the voting power to elect the directors is less than 50 percent, the maximum amount allowed by applicable law.

(3) In the case of an entity other than a corporation, 50 percent or more ownership interest in the entity, or the power to direct the management of the entity.

*c.* “Web search portal business” means an entity among whose primary businesses is to provide a search portal to organize information; to access, search, and navigate the internet, including research and development to support capabilities to organize information; and to provide internet access, navigation, and search functionalities.

**230.10(2) Criteria to claim exemption.** The following govern whether a business qualifies for an exemption from sales and use tax on purchases made or leases executed by a web search portal business:

*a.* All of the following requirements must be met by a web search portal business for the purpose of this exemption:

(1) The business of the purchaser or lessee shall be as a provider of a web search portal.

(2) The web search portal business shall have a physical location in Iowa that is used for the operations and maintenance of the web search portal site on the internet, including but not limited to research and development to support capabilities to organize information and to provide internet access, navigation, and search.

(3) The web search portal business shall make a minimum investment in an Iowa physical location of \$200 million within the first six years of operation in Iowa beginning with the date the web search portal business initiates site preparation activities. The minimum investment includes the initial investment, including land and subsequent acquisition of additional adjacent land and subsequent investment at the Iowa location.

(4) The web search portal business shall purchase, option, or lease Iowa land not later than December 31, 2008, for any initial investment. However, the December 31, 2008, date shall not affect the future purchases of adjacent land and additional investment in the initial or adjacent land to qualify as part of the minimum investment for purposes of this exemption.

*b.* Aggregation to meet requirements. A web search portal business that is seeking an exemption from sales and use tax under this exemption may meet the requirements found in subparagraphs 230.10(2)“a”(1) to (4) above, by aggregating various Iowa investments and other requirements with its business affiliates.

*c.* Failure to meet investment qualifications. If a web search portal business claiming exemption from sales and use tax under this exemption fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the web search portal business, the web search portal business will lose the right to claim this exemption from sales and use tax. Immediately following the loss of the right to claim this exemption from sales and use tax, the web search portal business is required to pay all sales or use taxes that would have been due on the purchase or rental of all purchases previously claimed exempt from sales and use tax, plus any and all applicable statutory penalty and interest due on the tax.

**230.10(3) Exempt purchases.** Sales and leases of the following are exempt from sales and use tax when sold or leased to a qualifying web search portal business:

- a. Computers and equipment that are necessary for the maintenance and operation of the web search portal business;
- b. All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the web search portal;
- c. All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph “b” above;
- d. All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the web search portal;
- e. All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the web search portal. This equipment includes, but is not limited to, exterior dedicated business-owned power substations, backup power generation systems, battery systems, and related infrastructure;
- f. All equipment used in the racking system, including cabling and trays;
- g. Fuel purchased by the web search portal business that is used in the backup power generation system and in all items listed in paragraphs “a” to “f.” This provision includes the fuel used in backup generators that may be located outside of the building that are used if power is interrupted to ensure the web search portal continues operation; and
- h. Electricity purchased for use in operating the web search portal.

**230.10(4) Limitation of exemption.** The purchases or leases of the items listed in subrule 230.10(3) are only exempt if the items being purchased or leased are being used in the operation or maintenance of the web search portal business. Such purchases or leases will not be exempt from sales or use tax if the item is to be used in the business for another purpose not related to operations or maintenance. Examples of items included in this limitation include but are not limited to:

- a. Electricity not used for operation or maintenance, such as in the office or employee break room;
- b. Tangible personal property used in areas of the web search portal facility that is not used for operation or maintenance, such as cleaning equipment and supplies;
- c. Building materials that become part of real property, such as concrete, steel or roofing; and
- d. Tangible personal property that becomes part of real property, such as a dishwasher.

**230.10(5) Initial date of exemption.** The exemption from sales and use tax begins on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying web search portal business.

This rule is intended to implement 2007 Iowa Code Supplement section 423.3(92).

**701—230.11(423) Web search portal business and its exemption.** Effective on or after July 1, 2008, a business that qualifies as a web search portal business that has a physical location in Iowa and that meets specific criteria may obtain an exemption from sales and use tax on specific purchases that are used in the operation and maintenance of the web search portal business. This exemption from sales and use tax also applies to the affiliates of a qualifying web search portal business.

**230.11(1) Definitions.** For the purpose of this exemption, the following definitions apply:

“*Affiliate*” means an entity that directly or indirectly controls, is controlled with or by, or is under common control with another entity.

“*Control*” means any of the following:

1. In the case of a United States corporation, the ownership, directly or indirectly, of 50 percent or more of the voting power to elect directors.
2. In the case of a foreign corporation, if the voting power to elect the directors is less than 50 percent, the maximum amount allowed by applicable law.
3. In the case of an entity other than a corporation, 50 percent or more ownership interest in the entity, or the power to direct the management of the entity.

“*Web search portal business*” means an entity whose business among other businesses is to provide a search portal to organize information; to access, search, and navigate the Internet, including research and development to support capabilities to organize information; or to provide Internet access, navigation, or search functionalities.

**230.11(2) Criteria to claim exemption.** The following governs whether a business qualifies for an exemption from sales and use tax on purchases made or leases executed by a web search portal business:

*a. Requirements.* All of the following requirements must be met by a web search portal business for the purpose of this exemption:

(1) The business, among other businesses, of the purchaser or lessee shall be as a provider of a web search portal.

(2) The web search portal business shall have a physical location in Iowa that is used for the operations and maintenance of the web search portal site on the Internet, including but not limited to research and development to support capabilities to organize information and to provide Internet access, navigation, and search functionality.

(3) The web search portal business shall make a minimum investment in an Iowa physical location of \$200 million within the first six years of operation in Iowa beginning with the date the web search portal business initiates site preparation activities. The minimum investment includes the initial investment, including land and subsequent acquisition of additional adjacent land and subsequent investment at the Iowa location.

(4) The web search portal business shall purchase, option, or lease Iowa land not later than December 31, 2008, for any initial investment. However, the December 31, 2008, date shall not affect the future purchases of adjacent land and additional investment in the initial or adjacent land to qualify as part of the minimum investment for purposes of this exemption.

*b. Aggregation to meet requirements.* A web search portal business that is seeking an exemption from sales and use tax under this exemption may meet the requirements found in subparagraphs 230.11(2)“a”(1) to (4) by aggregating various Iowa investments and other requirements with its business affiliates.

*c. Failure to meet investment qualifications.* If a web search portal business claiming exemption from sales and use tax under this exemption fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the web search portal business, the web search portal business will lose the right to claim this exemption from sales and use tax. Immediately following the loss of the right to claim this exemption from sales and use tax, the web search portal business is required to pay all sales or use taxes that would have been due on the purchase or rental of all purchases previously claimed exempt from sales and use tax, plus any and all applicable statutory penalty and interest due on the tax.

**230.11(3) Exempt purchases.** Sales and leases of the following are exempt from sales and use tax when sold or leased to a qualifying web search portal business:

*a.* Computers and equipment that are necessary for the maintenance and operation of the web search portal business;

*b.* All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the web search portal business;

*c.* All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph “b”;

*d.* All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the web search portal business;

*e.* All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the web search portal business. This equipment includes, but is not limited to, exterior dedicated business-owned power substations; and back-up power generation systems, battery systems, and related infrastructure;

*f.* All equipment used in the racking system, including cabling and trays;

*g.* Fuel purchased by the web search portal business that is used in the back-up power generation system and in all items listed in paragraphs “a” to “f.” This includes the fuel used in the back-up generators that may be located outside the building and that are used if power is interrupted to ensure the web search portal business continues operation; and

*h.* Electricity purchased for use in operating the web search portal business.

**230.11(4) *Limitation of exemption.*** The purchase or lease of the items listed in subrule 230.11(3) is only exempt if the items being purchased or leased are being used in the operation or maintenance of the web search portal business. Such purchases or leases will not be exempt from sales or use tax if the item is to be used in the business for another purpose. For example, the purchase of electricity for use in the office portion of the web search portal facility would not be exempt. The purchase of building materials that become real property would not be exempt. For example, the purchase of a dishwasher that will be built into a kitchen area in the break room for employees would not be exempt from tax. The purchase of a dishwasher is the purchase of tangible personal property. However, upon installation, the dishwasher becomes part of the building and realty and is not exempt from Iowa sales or use tax.

**230.11(5) *Initial date of exemption.*** The exemption from sales and use tax begins on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying web search portal business.

This rule is intended to implement Iowa Code section 423.3 as amended by 2008 Iowa Acts, House File 2233, section 1.

**701—230.12(423) Large data center business exemption.** Effective on or after July 1, 2009, a data center business that has a physical location in Iowa and that meets specific criteria may obtain an exemption from sales and use tax on specific purchases that are used in the operation and maintenance of the data center business.

**230.12(1) *Definitions.*** For the purpose of this rule, the following definitions apply:

“*Data center*” means a building rehabilitated or constructed to house a group of networked server computers in one physical location in order to centralize the storage, management, and dissemination of data and information pertaining to a particular business, taxonomy, or body of knowledge.

“*Data center business*” means an entity whose business, among other businesses, is to operate a data center.

**230.12(2) *Criteria to claim exemption.*** The following govern whether a business qualifies for an exemption from sales and use tax on purchases made or leases executed by a data center business:

*a. Requirements.* All of the following requirements must be met by a data center business for the purpose of this exemption:

(1) The business, among other businesses, of the purchaser or lessee shall be as a provider of a data center.

(2) The data center business shall have a physical location in Iowa that is, in the aggregate, at least 5,000 square feet in size used for the operation and maintenance of the data center.

1. A data center facility includes, but is not limited to, the centralization, storage, management and dissemination of data and information.

2. The physical location shall include the mechanical and electrical systems, redundant or backup power supplies, redundant data communications connections, environmental controls, and fire suppression systems for the data center business. The data center business’s physical location may also include a restricted access area employing advanced physical security measures such as video surveillance systems and card-based security or biometric security access systems.

(3) The data center business shall make a minimum investment in an Iowa physical location of \$200 million within the first six years of operation in Iowa beginning with the date the data center business initiates site preparation activities. The minimum investment includes the initial investment, including land and subsequent acquisition of additional adjacent land and subsequent investment at the Iowa location.

(4) The data center business shall comply with the applicable sustainable design and construction standards in Iowa Administrative Code 661—Chapter 310 as established by the state building code commissioner pursuant to Iowa Code section 103A.8B.

*b. Failure to meet investment qualifications.* If a data center business claiming exemption from sales and use tax under this exemption fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the data center business, the data center business will lose the right to claim this exemption

from sales and use tax. Immediately following the loss of the right to claim this exemption from sales and use tax, the data center business is required to pay all sales and use taxes that would have been due on the purchase or rental of all purchases previously claimed exempt from sales and use tax, plus any and all applicable statutory penalty and interest due on the tax.

**230.12(3) Exempt purchases.** Sales and leases of the following are exempt from sales and use tax when sold or leased to a qualifying data center business:

- a. Computers and equipment that are necessary for the maintenance and operation of the data center business;
- b. All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the data center business;
- c. All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph “b”;
- d. All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the data center business;
- e. All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the data center business. This equipment includes, but is not limited to, exterior dedicated business-owned power substations and backup power generation systems, battery systems, and related infrastructure;
- f. All equipment used in the racking system, including cabling and trays;
- g. Fuel purchased by the data center business that is used in the backup power generation system and in all items listed in paragraphs “a” to “f.” This includes the fuel used in the backup generators that may be located outside the building and that are used if power is interrupted to ensure the data center business continues operation; and
- h. Electricity purchased for use in operating the data center business.

**230.12(4) Limitation of exemption.** The purchase or lease of the items listed in subrule 230.12(3) is only exempt if the items being purchased or leased are being used in the operation or maintenance of the data center business. Such purchases or leases will not be exempt from sales or use tax if the item is to be used in the business for another purpose. For example:

- a. The purchase of electricity for use in the office portion of the data center business facility would not be exempt.
- b. The purchase of building materials that become real property would not be exempt. For example, the purchase of a dishwasher that will be built into a kitchen area in the break room for employees would not be exempt from tax. Although the purchase of a dishwasher is the purchase of tangible personal property, upon installation, the dishwasher becomes part of the building and realty and, therefore, is not exempt from Iowa sales and use tax.

**230.12(5) Initial date of exemption.** The exemption from sales and use tax begins on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying data center business.

This rule is intended to implement Iowa Code section 423.3 as amended by 2009 Iowa Acts, Senate File 478, sections 197 through 202.

[ARC 8602B, IAB 3/10/10, effective 4/14/10]

**701—230.13(423) Data center business sales and use tax refunds.** Effective on or after July 1, 2009, data center businesses in Iowa meeting certain criteria may make an annual application to the department for a refund of 50 percent of the sales and use tax paid on the sales price of certain computers, equipment, fuel, and electricity used in the operation of the data center business.

**230.13(1) Definitions.** For the purpose of this rule, the following definitions apply:

“Data center” means a building rehabilitated or constructed to house a group of networked server computers in one physical location in order to centralize the storage, management, and dissemination of data and information pertaining to a particular business, taxonomy, or body of knowledge.

“*Data center business*” means an entity whose business, among other businesses, is to operate a data center.

“*Refund year*” means the year beginning with the date of initial site preparation of the data center facility.

“*Rehabilitation*” means a process of substantial repair, remodeling, or alteration, which may include but is not limited to upgrading mechanical systems, plumbing, roofing, wiring, windows, and heating and cooling systems, and performing significant interior or exterior structural modification. Although they may be included as part of an overall rehabilitation project, singular actions such as the installation of a new information system or cosmetic changes to the interior or exterior appearance of a building do not, in and of themselves, constitute a rehabilitated building.

**230.13(2) Basis and criteria for refunds.** The amount, type, and length of refunds available to data center businesses depend upon the dollar amount of investment made, the type of construction undertaken, and the size in square feet of the facility.

*a. Investment of \$136 million to \$200 million.* Data center businesses which make investments in an Iowa facility of \$136 million to \$200 million in the first six years of operations and which facility contains at least 5,000 square feet are eligible for a refund of 50 percent of the sales and use tax paid on qualifying computers and equipment, backup fuel, and electricity for the first seven years of operation.

*b. Investment of \$10 million to \$136 million—new construction.* Data center businesses which make investments of \$10 million to \$136 million in the first six years of operations in the new construction of an Iowa facility that is at least 5,000 square feet are eligible for a refund of 50 percent of the sales and use tax paid on qualifying computers and equipment, backup fuel, and electricity for the first ten years of operation.

*c. Investment of \$5 million to \$136 million—rehabilitation.* Data center businesses which make investments of \$5 million to \$136 million in the first six years of operations in the rehabilitation of an Iowa facility that is at least 5,000 square feet are eligible for a refund of 50 percent of the sales and use tax paid on qualifying computers and equipment, backup fuel, and electricity for the first ten years of operation.

*d. Investment of \$1 million to \$10 million—new construction.* Data center businesses which make investments of \$1 million to \$10 million in the first three years of operations in the new construction of an Iowa facility of any size are eligible for a refund of 50 percent of the sales and use tax paid on fuel and electricity for the first five years of operation.

*e. Investment of \$1 million to \$5 million—rehabilitation.* Data center businesses which make investments of \$1 million to \$5 million in the first three years of operations in the rehabilitation of an Iowa facility of any size are eligible for a refund of 50 percent of the sales and use tax paid on fuel and electricity for the first five years of operation.

**230.13(3) Purchases eligible for refunds.** Sales and leases of the following are eligible for a refund of 50 percent of the sales and use tax paid when sold or leased to a qualifying data center business:

*a.* Computers and equipment that are necessary for the maintenance and operation of the data center business;

*b.* All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the data center business;

*c.* All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph “*b*”;

*d.* All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the data center business;

*e.* All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the data center business. This equipment includes, but is not limited to, exterior dedicated business-owned power substations and backup power generation systems, battery systems, and related infrastructure;

*f.* All equipment used in the racking system, including cabling and trays;

g. Fuel purchased by the data center business that is used in the backup power generation system and in all items listed in paragraphs “a” to “f.” This includes the fuel used in the backup generators that may be located outside the building and that are used if power is interrupted to ensure the data center business continues operation; and

h. Electricity purchased for use in operating the data center business.

**230.13(4) Sustainable design standards.** In order to claim the refunds detailed in subrule 230.13(3), paragraphs “a” through “h,” data center businesses must comply with the sustainable design and construction standards as required by Iowa Administrative Code 661—Chapter 310 as established by the state building code commissioner pursuant to Iowa Code section 103A.8B.

**230.13(5) Failure to meet investment qualifications.** If a data center business claiming a refund of sales and use tax under this rule fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the data center business, the data center business will lose the right to claim the refund of sales and use tax. Immediately following the loss of the right to claim the refund of sales and use tax, the data center business is required to return the refund of sales and use tax paid on qualifying computers, equipment, fuel, and electricity, plus any and all applicable statutory penalty and interest due on the tax.

**230.13(6) Limitation of refunds.**

a. *Use in operation or maintenance.* The purchase or lease of the items listed in subrule 230.13(3) is only eligible for a refund of sales and use tax if the items being purchased or leased are being used in the operation or maintenance of the data center business. Such purchases or leases will not be eligible for a refund of sales and use tax if the item is to be used in the business for another purpose. For example:

(1) The purchase of electricity for use in the office portion of the data center business facility would not be eligible for a refund.

(2) The purchase of building materials that become real property would not be eligible for a refund. For example, the purchase of a dishwasher that will be built into a kitchen area in the break room for employees would not be eligible for a refund of tax. Although the purchase of a dishwasher is the purchase of tangible personal property, upon installation, the dishwasher becomes part of the building and realty and, therefore, is not eligible for a refund of Iowa sales and use tax.

b. *State sales tax only.* Refunds issued under this rule may not exceed 5 percent of the sales price of computers and equipment listed in subrule 230.13(3) and the fuel used to create heat, power and steam for processing or generating electrical current or from the sales price of electricity consumed by computers, machinery, or other equipment for operation of the data center business facility. The refund will not include any local option sales and services taxes.

c. *Qualifying dates for fuel and electricity refund.* To qualify for the 50 percent refund, the following must be on or after the first day of the first month through the last day of the last month of the refund year:

(1) The dates of the utility billing or meter reading cycle for the sale or furnishing of metered gas and electricity;

(2) The dates of the sale or furnishing of fuel for purposes of commercial energy; and

(3) The delivery of the fuel used for purposes of commercial energy.

**230.13(7) Form and filing requirements.**

a. *Form.* The owner of a data center business seeking a refund of sales and use tax imposed upon the sale or lease of any qualifying computers, equipment, fuel, and electricity must complete and file with the department Form IA 843, Claim for Refund. All of the information on the Claim for Refund must be completed.

b. *Due date.* The refund request form must be filed with the department no later than one year after the purchase of the qualifying computers, equipment, fuel, or electricity and within three months after the end of the refund year. The refund for sales and use tax begins with purchases made on and after July 1, 2009, or on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying data center business.

c. *Date required.* The refund request must include detailed schedules of the items being claimed including dates of purchase of tangible personal property, amount of purchase, and tax paid. The purchase of fuel and electricity must be computed and documented separately from other purchases.

d. *Affidavit.* In addition to completing and filing Form IA 843, Claim for Refund, the owner of a data center business seeking a refund as specified in this rule must also complete and file with the department an affidavit certifying that qualifications for the refund have been met. The affidavit must be filed prior to any refund request and must be approved by the department before a refund claim can be filed. The following format must be used for the affidavit:

Iowa Department of Revenue  
Sales Tax Refund Affidavit

NAME OF AFFIANT	}	AFFIDAVIT FOR
ADDRESS OF AFFIANT		DATA CENTER BUSINESS

The undersigned duly swears that the named data center business complies with criteria to be entitled to refund of sales tax as required in Iowa Code section 423.4 as follows:

1. The facility is a data center business as defined by Iowa Code section 423.4(8) or 423.4(9);
2. The data center business facility will be a minimum of 5,000 square feet, as applicable, located upon Iowa land; and located at \_\_\_\_\_; with total square footage of \_\_\_\_\_;
3. The data center business will make an investment of (check only one):
  - \$136 million to \$200 million within the first six years of operation (refund available for first seven years).
  - \$10 million to \$136 million for new construction within the first six years of operation (refund available for first ten years).
  - \$5 million to \$136 million for rehabilitation of an existing facility within the first six years of operation (refund available for first ten years).
  - \$1 million to \$10 million for new construction within the first three years of operation (refund of tax paid on fuel and electricity only; refund available for first five years).
  - \$1 million to \$5 million for rehabilitation of an existing facility within the first three years of operation (refund of tax paid on fuel and electricity only; refund available for first five years).
4. The data center business facility will be constructed in accordance with the sustainable design and construction standards as required by Iowa Administrative Code 661—Chapter 310 and established by the building code commissioner pursuant to Iowa Code section 103A.8B;
5. Construction of the data center business facility was commenced on or after July 1, 2009; and the date of the initial site preparation or building rehabilitation was \_\_\_\_\_; and
6. Purchases of qualifying computers, equipment, fuel or electricity were made on or after July 1, 2009.

The undersigned duly swears that he or she is the owner of the qualifying data center business or that the undersigned is the authorized representative of the qualifying data center business and has the authority to sign this document. The undersigned swears that he or she has personal knowledge regarding the facts contained in this affidavit and that the statements set forth in this affidavit are true and accurate and that the qualifying data center business has met all of the requirements as contained herein.

\_\_\_\_\_  
Name of Affiant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Position of Affiant

**701—230.14(423) Exemption for the sale of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment used for certain manufacturing purposes if the sale occurs as part of a contract entered into on or after July 1, 2016.** Rules 701—230.14(423) to 701—230.20(423) exempt the sales price of computers, machinery, and equipment used in an exempt manufacturing purpose. Rule 701—230.21(423) exempts the purchase of fuel used in such machinery and equipment. Rule 701—230.22(423) exempts the service of designing or installing such machinery and equipment. Rules 701—230.14(423) to 701—230.22(423) apply to sales of such products occurring as part of a contract entered into on or after July 1, 2016. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423). A sale occurs as part of a contract entered into prior to July 1, 2016, if the purchaser enters into a contract with a retailer to purchase the product and the contract date is prior to July 1, 2016, or if the purchaser enters into a contract with a contractor, subcontractor, or builder to construct or assemble the property and the contract date is prior to July 1, 2016.

**230.14(1) Generally.** The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax if the property is any of the following:

- a. Directly and primarily used in processing by a manufacturer (see rule 701—230.15(423)).
- b. Directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, machinery, and equipment used in processing by a manufacturer, including test equipment used to control quality and specifications of the product (see rule 701—230.16(423)).
- c. Directly and primarily used in research and development of new products or processes of processing (see rule 701—230.17(423)).
- d. Computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise (see rule 701—230.18(423)).
- e. Directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).
- f. Pollution-control equipment used by a manufacturer, including but not limited to that required or certified by an agency of this state or of the United States government (see rule 701—230.20(423)).
- g. Fuel used in creating heat, power, steam, or for generating electrical current, or from the sale of electricity, consumed by computers, machinery, or equipment used in an exempt manner described in paragraph “a,” “b,” “c,” “e,” or “f” (see rule 701—230.21(423)).

**230.14(2) Computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment.**

a. *Computers.* A “computer” is an electronic device that accepts information in digital or similar form and manipulates the information for a result based on a sequence of instructions. A computer includes all devices fastened to it by means of signal cables or any communication medium that serves the function of a signal cable. Nonexclusive examples of devices fastened by a signal cable or other communication medium are terminals, printers, display units, card readers, tape readers, document sorters, optical readers, and card or tape punchers. A computer also includes any operating system or executive program, but not application software, purchased as part of the sale of the computer for which the operating system or executive program operates. For purposes of this paragraph, “operating system or executive program” means computer software that is fundamental and necessary to the functioning of a computer. The operating system or executive program controls the operation of a computer by managing the allocation of all system resources, including the central processing unit, main and secondary storage, input/output devices, and the processing of programs. This is in contrast to application software, which is a collection of one or more programs used to develop and implement the specific applications that the computer is to perform and which calls upon the services of the operating system or executive program. Application software, or an operating system or executive program priced separately or sold at a later time from the computer for which the operating system or executive program operates, may be taxable as “prewritten computer software.” See rule 701—211.1(423).

*b. Machinery.* “Machinery” is any mechanical, electrical, or electronic device designed and used to perform some function and to produce a certain effect or result. Machinery also includes all devices used or required to control, regulate, or operate a piece of machinery, provided such devices are directly connected with or are an integral part of the machinery and are used primarily for control, regulation, or operation of machinery. Jigs, dies, tools, and other devices necessary to the operation of or used in conjunction with the operation of what would be ordinarily thought of as machinery are also considered to be machinery. All property that is in the nature of machinery (other than structural components of a building or other inherently permanent structure) is considered tangible personal property even if located outside of a building. A structure that is essentially machinery remains tangible personal property for purposes of this paragraph. For more information on distinguishing machinery from buildings and other constructed realty, see subparagraph 230.14(2) “f”(1).

*c. Equipment.* In general usage, “equipment” refers to devices or tools used to produce a final product or achieve a given result. Equipment includes supplies that do not qualify as “replacement parts,” such as drill bits, grinding wheels, punches, taps, reamers, saw blades, lubricants, coolants, sanding discs, sanding belts, and air filters. All property that is in the nature of equipment (other than structural components of a building or other inherently permanent structure) is considered tangible personal property even if located outside of a building. A structure that is essentially equipment may remain tangible personal property for purposes of this paragraph. For more information on distinguishing equipment from buildings and other constructed realty, see subparagraph 230.14(2) “f”(1).

*d. Replacement parts.* “Replacement part” means tangible personal property other than computers, machinery, or equipment, regardless of the cost or useful life of such tangible personal property. A replacement part can be separated from the computer, machinery, or equipment. A “replacement part” is a part or component of a computer, machinery, or equipment that came with the original item purchased or has been added over time to improve or restore the computer, machinery, or equipment.

*e. Materials used to construct or self-construct computers, machinery, and equipment.* “Materials used to construct or self-construct computers, machinery, and equipment” means tangible personal property that is incorporated into a computer, machinery, or equipment when the computer, machinery, or equipment is constructed or assembled. Materials used to construct a structure that is essentially machinery or equipment are exempt from sales and use tax so long as the machinery or equipment is used in an exempt manner under rules 701—230.14(423) to 701—230.20(423).

*f. Exclusions.* Sales of the following property, or materials used to construct or self-construct the following property, are not exempt under rules 701—230.14(423) to 701—230.20(423) regardless of how the property is used.

(1) Constructed realty.

1. Generally. Iowa Code section 423.2(1) “b” and “c” imposes sales and use tax upon building materials, supplies, and equipment used for the erection of buildings or other realty. However, Iowa Code section 423.3(47) exempts from sales and use tax certain computers, machinery, and equipment as well as items used to construct or self-construct certain computers, machinery, and equipment. Determining whether constructed items are realty or exempt computers, machinery, or equipment under Iowa Code section 423.3(47) ultimately depends on the use of the items. In general, exempt computers, machinery, and equipment under Iowa Code section 423.3(47) are tangible personal property when purchased, and they remain tangible personal property after installation. Materials used to construct realty remain taxable when purchased by the contractor, subcontractor, or builder under Iowa Code section 423.2(1) “b” and “c.” For more information about sales and use tax on construction activities, see 701—Chapter 219.

2. Distinguishing constructed realty from tangible personal property. For purposes of rules 701—230.14(423) to 701—230.22(423), an item remains tangible personal property after installation if all of the following apply:

- The item can be removed without causing material damage or injury to the item or to the building that houses it or the real property upon which it is located;
- The item does not bear the weight of a building or other realty;

- The item does not in any other manner constitute an integral part of a building or other realty; and

- The item is used in an exempt manner under rules 701—230.14(423) to 701—230.20(423).

3. Buildings. Buildings are constructed realty. A “building” is any structure or edifice enclosing a space within its walls, and usually covered by a roof, the purpose of which is, for example, to provide shelter or housing for machinery or equipment or to provide working, office, parking, display, or sales space. Materials used to construct a building or any other realty are not exempt under rules 701—230.14(423) to 701—230.20(423), even if the realty is specially designed to house exempt computers, machinery, or equipment.

4. Examples.

- Property that, under normal conditions, remains tangible personal property after installation for purposes of rules 701—230.14(423) to 701—230.22(423) includes, but is not limited to:

- Storage tanks that rest upon a foundation and are secured with bolts.

- Industrial piping systems directly and primarily used in processing.

- Cooling towers directly and primarily used in processing.

- Structural steel, if exposed and used to support other computers, machinery, or equipment.

- Property that, under normal conditions, becomes constructed realty after installation for purposes of rules 701—230.14(423) to 701—230.22(423) includes, but is not limited to:

- Underground storage tanks constructed on site.

- Foundations made of concrete or other materials, regardless of whether they are used exclusively as platforms for machinery and equipment.

- Cooling towers primarily used to cool a building or other constructed realty.

- Structural steel, if used to construct a building or other constructed realty.

(2) Land.

(3) Intangible property.

(4) Hand tools. “Hand tool” means a tool that can be held in the hand or hands and is powered by human effort.

(5) Point-of-sale equipment and computers. “Point-of-sale equipment and computers” means input, output, and processing equipment used to consummate a sale and to record or process information pertaining to a sale transaction at the time the sale takes place and is located at the counter, desk, or other specific point where the transaction occurs.

(6) Certain centrally assessed industrial machinery, equipment, and computers. Property that is centrally assessed by the department of revenue under Iowa Code sections 428.24 to 428.29 or chapters 433, 434, 437, 437A, 437B, and 438 does not qualify for exemption under rules 701—230.14(423) to 701—230.20(423). Property used but not owned by persons whose property is defined by such provisions of the Iowa Code, which would be assessed by the department of revenue if the persons owned the property, also does not qualify for exemption under rules 701—230.14(423) to 701—230.20(423).

(7) Vehicles subject to registration. The general sales and use tax does not apply to vehicles subject to registration under Iowa Code chapter 321. Instead, such vehicles are subject to the fee for new registration under Iowa Code section 321.105A. Vehicles subject to registration are not exempt from the fee for new registration under rules 701—230.14(423) to 701—230.20(423), unless the vehicle is directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).

*g. Examples.* When used for an exempt purpose under rules 701—230.14(423) to 701—230.20(423), the following items may be exempt computers, machinery, or equipment. This list is not all-inclusive.

(1) Coolers, including coolers that do not change the nature of materials stored in them.

(2) Equipment that eliminates bacteria.

(3) Palletizers.

(4) Storage bins.

(5) Property used to transport raw, semifinished, or finished goods.

(6) Vehicle-mounted cement mixers.

(7) Self-constructed machinery and equipment.

- (8) Packaging and bagging equipment, including conveyer systems.
- (9) Equipment that maintains an environment necessary to preserve a product's integrity.
- (10) Equipment that maintains a product's integrity directly.
- (11) Quality control equipment.

**230.14(3) *Leased and rented property.*** The exemptions under rules 701—230.14(423) to 701—230.22(423) apply to property regardless of how it is sold, including leased or rented property. The lease of computers, machinery, or equipment may be exempt from sales and use tax if the lessee uses the property in an exempt manner under rules 701—230.14(423) to 701—230.20(423). Additionally, a lessor's purchase of computers, machinery, or equipment for lease may be an exempt sale for resale under Iowa Code section 423.3(2).

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.15(423) Exemption for the sale of property directly and primarily used in processing by a manufacturer if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used in processing by a manufacturer. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

**230.15(1) *Required elements.*** To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, or equipment (see subrule 230.14(2));
- b. Directly used (see subrule 230.15(2));
- c. Primarily used (see subrule 230.15(2));
- d. Used in processing (see subrule 230.15(3)); and
- e. Used by a manufacturer (see subrule 230.15(4)).

**230.15(2) *Directly and primarily used.***

a. *Directly used.*

(1) Generally. Property is “directly used” only if it is used to initiate, sustain, or terminate an exempt activity. In determining whether any property is “directly used,” consideration should be given to the following factors:

- 1. The physical proximity of the property to the exempt activity;
- 2. The temporal proximity of the use of the property to the use of other property that is directly used in the exempt activity; and
- 3. The active causal relationship between the use of the property and the exempt activity. The fact that a particular piece of property may be essential to the conduct of the activity because its use is required either by law or practical necessity does not, of itself, mean that the property is directly used.

(2) Examples. The following property typically is not directly used in an exempt manner:

- 1. Property used exclusively for the comfort of workers, such as air cooling, air conditioning, or ventilation systems.
- 2. Property used in support operations, such as a machine shop, where production machinery is assembled, maintained, or repaired.
- 3. Property used by administrative, accounting, or personnel departments.
- 4. Property used by security, fire prevention, first aid, or hospital stations.
- 5. Property used in communications or safety.

b. *Primarily used.* The primary use of property is the activity or activities for which the property is used more than half of the time.

**230.15(3) *Processing.***

a. *Generally.* “Processing” means a series of operations in which materials are manufactured, refined, purified, created, combined, transformed, or stored by a manufacturer, ultimately into tangible personal property. Processing encompasses all activities commencing with the receipt or producing of raw materials by the manufacturer and ending at the point products are delivered for shipment or

transferred from the manufacturer. Processing includes, but is not limited to, refinement or purification of materials; treatment of materials to change their form, context, or condition; maintenance of the quality or integrity of materials, components, or products; maintenance of environmental conditions necessary for materials, components, or products; quality control activities; construction of packaging and shipping devices; placement into shipping containers or any type of shipping device or medium; and the movement of materials, components, or products until shipment from the processor. "Receipt or producing of raw materials" means activities performed upon tangible personal property only. With respect to raw materials produced from or upon real estate, "production of raw materials" is deemed to occur immediately following the severance of the raw materials from the real estate.

*b. The beginning of processing.* Processing begins with a processor's receipt or production of raw material. Thus, when a processor produces its own raw material, it is engaged in processing. Processing also begins when a supplier transfers possession of raw materials to a processor.

*c. The completion of processing.* Processing ends when the finished product is transferred from the processor or delivered for shipment by the processor. Therefore, a processor's packaging, storage, and transport of a finished product after the product is in the form in which it will be sold at retail are part of the processing of the product.

*d. Examples of the beginning, intervening steps, and the ending of processing.* Of the following, Examples A and B illustrate when processing begins under various circumstances; Example C demonstrates the middle stages of processing; and Example D demonstrates when the end of processing takes place.

**EXAMPLE A:** Company A manufactures fine furniture. Company A owns a grove of walnut trees that it uses as raw material. Company A's employees cut the trees, transport the logs to Company A's facility, store the logs in a warehouse to begin the curing process, and eventually take the logs to Company A's sawmill. The walnut trees are real property while they are growing. Thus, no "production of raw materials" has occurred with regard to the trees until they have been severed from the soil and transformed into logs. Processing of the logs begins when they are placed on vehicles for transport to Company A's factory. However, if the transport vehicles are "vehicles subject to registration," they are not exempt from the fee for new registration under this rule (see subparagraph 230.14(2) "f"(7)).

**EXAMPLE B:** Company A from the previous example also buys mahogany logs from a supplier in Honduras. Company A uses its equipment to offload the logs from railroad cars at its facility. Company A then stores and saws the logs as previously described in Example A. Processing begins when Company A offloads the logs from the railroad cars.

**EXAMPLE C:** Company C is a microbrewery. It uses a variety of kettles, vats, tanks, tubs, and other containers to mix, cook, ferment, settle, age, and store the beer it brews. Company C also uses a variety of pipes and pumps to move the beer among the various containers involved in the activity of brewing. All stages of this brewing are part of processing, including fermentation or aging (the transformation of the raw materials from one state to another) as well as the storage of hops in a bin and the storage of beer prior to bottling (the holding of materials in an existing state). Any movement of the product between containers is also a part of processing.

**EXAMPLE D:** After the brewing process is complete, Company C places its beer in various containers, stores the beer, and moves the beer to Company C's customers by a common carrier that picks up the beer at Company C's facility. Company C's activities of placing the beer into bottles, cans, and kegs, storing it after packaging, and moving the beer by use of a forklift to the common carrier's pickup site are part of processing.

#### **230.15(4) Manufacturer.**

*a. Generally.* "Manufacturer" means a person that purchases, receives, or holds personal property of any description for the purpose of adding to its value by a process of manufacturing, refining, purifying, or combining of different materials, or by the packing of meats, with a view to selling the property for gain or profit, but also includes contract manufacturers. A "contract manufacturer" is a manufacturer that otherwise falls within the definition of manufacturer, except that a contract manufacturer does not sell the tangible personal property the contract manufacturer processes on behalf of other manufacturers. A business engaged in activities subsequent to the extractive process of quarrying or mining, such as

crushing, washing, sizing, or blending of aggregate materials, is a manufacturer with respect to these activities. A person does not need to be primarily engaged in an activity listed in this subrule in order to qualify as a manufacturer for purposes of this rule.

*b. Nonexclusive examples.* Those who are in the business of printing, newspaper publication, bookbinding, lumber milling, and production of drugs and agricultural supplies are illustrative, nonexclusive examples of manufacturers. Construction contracting; repairing of tangible personal property (such as automobile engines); provision of health care; farming; transportation for hire; and the activities of restaurateurs, hospitals, medical doctors, and those who merely process data are illustrative, nonexclusive examples of businesses that ordinarily are not manufacturers.

EXAMPLE A: Company A owns and operates a gravel pit. Company A sells the gravel extracted from the pit to others who use the gravel for surfacing roads and as an ingredient in concrete manufacture. Company A removes overlay and raw gravel from the pit and then transports the gravel to a plant where washing and sizing of the gravel take place. Company A is a manufacturer, but only with respect to those activities that occur after it extracts the gravel from the ground.

EXAMPLE B: Company B owns a manufacturing plant. Company B also owns a machine shop where it uses a metal press machine to fabricate patterns. All of these patterns are used in Company B's manufacturing plant as part of processing, and the metal press machine is used solely to fabricate these patterns. The sales price of the metal press machine is not exempt from sales and use tax under this rule because Company B does not use the metal press machine to manufacture a product for sale at a gain or profit. However, the computers, machinery, and equipment in Company B's manufacturing plant may be exempt if they are directly and primarily used in processing.

This rule is intended to implement Iowa Code section 423.3(47) "a"(1).  
[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.16(423) Exemption for the sale of property directly and primarily used by a manufacturer to maintain integrity or unique environmental conditions if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, machinery, and equipment used in processing by a manufacturer, including test equipment used to control quality and specifications of the product. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

**230.16(1) Required elements.** To qualify for exemption under this rule, the purchaser must prove the property is:

- a.* Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, and equipment (see subrule 230.14(2));
- b.* Directly used (see subrule 230.15(2));
- c.* Primarily used (see subrule 230.15(2));
- d.* Used by a manufacturer (see subrule 230.15(4)); and
- e.* Used to maintain:
  - (1) A manufactured product's integrity;
  - (2) Unique environmental conditions required for a manufactured product; or
  - (3) Unique environmental conditions required for other computers, machinery, or equipment directly and primarily used in processing by a manufacturer.

**230.16(2) Example of property directly and primarily used to maintain integrity or unique environmental conditions.** A manufacturer purchases a cooling tower to directly and primarily maintain the proper temperature of its machinery and equipment. The manufacturer uses such machinery and equipment directly and primarily in processing. Because the cooling tower maintains the environmental conditions necessary for machinery and equipment that is directly and primarily used in processing,

the cooling tower and materials used to construct or self-construct the cooling tower are exempt from sales and use tax under this rule.

This rule is intended to implement Iowa Code section 423.3(47) “a”(2).  
[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.17(423) Exemption for the sale of property directly and primarily used in research and development of new products or processes of processing if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used in research and development of new products or processes of processing. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

**230.17(1) Required elements.** To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, and equipment (see subrule 230.14(2));
- b. Directly used (see subrules 230.15(2) and 230.17(3));
- c. Primarily used (see subrule 230.15(2)); and
- d. Used in research and development (see subrule 230.17(2)) of:
  - (1) New products; or
  - (2) Processes of processing.

**230.17(2)** “Research and development” means experimental or laboratory activity that has as its ultimate goal the development of new products or processes of processing.

**230.17(3)** Property is used “directly” in research and development only if it is used in actual experimental or laboratory activity that qualifies as research and development under this rule.

**230.17(4)** Example of property directly and primarily used in research and development of new products or processes of processing. A hybrid seed producer maintains a research and development laboratory for use in developing new varieties of corn seed. The hybrid seed producer purchases the following items for use in its research and development laboratory: a laboratory computer for processing data related to the genetic structure of various corn plants, an electron microscope for examining the structure of corn plant genes, a steam cleaner for cleaning rugs in the laboratory offices, and a desktop computer for use by the laboratory receptionist. The laboratory computer and the microscope are “directly” used in the research in which the laboratory is engaged; the steam cleaner and the receptionist’s computer are not directly used in research. Therefore, the sales prices of the laboratory computer and the microscope are exempt from sales and use tax. The sales prices of the steam cleaner and the receptionist’s computer are not exempt from tax under this rule.

This rule is intended to implement Iowa Code section 423.3(47) “a”(3).  
[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.18(423) Exemption for the sale of computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price of computers is exempt from sales tax when the computers are used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

**230.18(1) Required elements.** To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers (see paragraph 230.14(2) “a”);
- b. Used in processing or storage of data or information (see subrule 230.18(2)); and
- c. Used by:
  - (1) An insurance company (see subrule 230.18(3));
  - (2) A financial institution (see subrule 230.18(3)); or
  - (3) A commercial enterprise (see subrule 230.18(3)).

**230.18(2)** *Processing or storage of data or information.* All computers store and process information. However, only if the “final output” for a user or consumer is stored or processed data will the computer be eligible for exemption from tax under this rule.

**230.18(3)** *Insurance company, financial institution, or commercial enterprise.*

*a. Insurance company.* An insurance company is an insurer organized or operating under Iowa Code chapter 508, 514, 515, 518, 518A, 519, or 520 or an insurer authorized to do business in Iowa as an insurer or as a licensed insurance producer under Iowa Code chapter 522B. Excluded from the definition of “insurance company” are benevolent associations governed by Iowa Code chapter 512A, fraternal benefit societies governed by Iowa Code chapter 512B, and health maintenance organizations governed by Iowa Code chapter 514B. This list of exclusions is not intended to be exclusive.

*b. Financial institution.* A financial institution is any bank incorporated under the provisions of any state or federal law, any savings and loan association incorporated under the provisions of federal law, any credit union organized under the provisions of any state or federal law, any corporation licensed as an industrial loan company under Iowa Code chapter 536A, and any affiliate of a bank, savings and loan association, credit union, or industrial loan company.

*c. Commercial enterprise.* A commercial enterprise is a business or manufacturer conducted for profit, other than an insurance company or financial institution. “Commercial enterprise” includes centers for data processing services to insurance companies, financial institutions, businesses, and manufacturers, but excludes professions and occupations as well as nonprofit organizations. A hospital that is a not-for-profit organization is not a commercial enterprise. The term “profession” means a vocation or employment requiring specialized knowledge and often long and intensive academic preparation. The term “occupation” means the principal business of an individual, such as the business of farming. A professional entity that carries on any profession or occupation, such as an accounting firm, is not a commercial enterprise.

**230.18(4)** *Examples of computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise.* A health insurance company has four computers. Computer A is used to monitor the temperature within the insurance company’s building. Computer A transmits messages to the building’s heating and cooling systems, which tell the systems when to raise or lower the level of heating or air conditioning. Computer B is used to store patient records and to recall those records on demand. Computer C is used to tabulate statistics regarding the amount of premiums paid in and the amount of benefits paid out for various classes of insured. Computer D is used to train the insurance company’s employees to perform various additional tasks or to better perform work the employees can already do. Computer D uses various canned programs to accomplish this function. The final output of Computer A is neither stored nor processed information. Therefore, Computer A does not meet the definition of an exempt computer. The final output of Computer B is stored information. The final output of Computer C is processed information. The final output of Computer D is processed information consisting of the training exercises appearing on the computer monitor. The sales prices of Computers B, C, and D are exempt from sales and use tax as computers used in processing or storage of data or information by an insurance company.

This rule is intended to implement Iowa Code section 423.3(47) “a”(4).

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.19(423) Exemption for the sale of property directly and primarily used in recycling or reprocessing of waste products if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used in recycling or reprocessing of waste products. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

**230.19(1)** *Required elements.* To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, and equipment (see subrule 230.14(2));
- b. Directly used (see subrule 230.15(2));
- c. Primarily used (see subrule 230.15(2)); and
- d. Used in:
  - (1) Recycling of waste products (see subrule 230.19(2)); or
  - (2) Reprocessing of waste products (see subrule 230.19(2)).

**230.19(2) *Recycling and reprocessing.***

a. “Recycling” is any process by which waste or materials that would otherwise become waste are collected, separated, or processed and revised or returned for use in the form of raw materials or products. Recycling includes, but is not limited to, the composting of yard waste that has been previously separated from other waste. Recycling does not include any form of energy recovery.

b. “Reprocessing” is not a subcategory of processing. Reprocessing of waste products is an activity separate and independent from the processing of tangible personal property.

c. Recycling or reprocessing generally begins when the waste products are collected or separated. Recycling or reprocessing generally ends when waste products are in the form of raw material or another non-waste product. Activities that occur between these two points and are an integral part of recycling or processing qualify as recycling or reprocessing.

**230.19(3) *Examples.***

a. Computers, machinery, and equipment that may be exempt from sales and use tax under this rule include, but are not limited to, compactors, balers, crushers, grinders, cutters, and shears if directly and primarily used in recycling or reprocessing.

b. End loaders, forklifts, trucks, conveyor systems, and other moving devices directly and primarily used in the movement of waste products during recycling or reprocessing may be exempt from sales and use tax under this rule.

c. A bin or other container used to store waste products before collection for recycling or reprocessing is not directly and primarily used in recycling or reprocessing, and its sales price is not exempt from sales and use tax under this rule.

d. A vehicle used directly and primarily for collecting waste products for recycling or reprocessing could be a vehicle used for an exempt purpose under this rule, and such a vehicle could be exempt from the fee for new registration. Thus, a garbage truck could qualify for this exemption if the truck is directly and primarily used in recycling; however, a garbage truck primarily used to haul garbage to a landfill does not qualify for exemption under this rule.

EXAMPLE A: Company A recycles household waste. Company A uses several machines in its facility to separate waste products into recyclable and nonrecyclable materials and to further separate the recyclable materials into paper, plastic, or glass. The sales prices of all separating machines are exempt from sales and use tax as machines directly and primarily used in recycling of waste products.

EXAMPLE B: Company B uses grinding machines to convert logs, stumps, pallets, crates, and other waste wood into wood chips. Company B then uses its trucks to deliver the wood chips to local purchasers. The sales prices of the grinding machines are exempt from sales and use tax as machines directly and primarily used in recycling or reprocessing of waste products. The trucks used to transport the wood chips are not used in recycling or reprocessing because the wood chips are in their final form when loaded onto the trucks.

This rule is intended to implement Iowa Code section 423.3(47) “a”(5).

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.20(423) Exemption for the sale of pollution control equipment used by a manufacturer if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price of pollution control equipment, including but not limited to equipment required or certified by an agency of Iowa or of the United States government, is exempt from sales and use tax when the property is used by a manufacturer. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

**230.20(1)** Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Pollution control equipment (See subrule 230.20(2)); and
- b. Used by a manufacturer (See subrule 230.15(4)).

**230.20(2)** “Pollution control equipment” is any disposal system or apparatus used or placed in operation primarily for the purpose of reducing, controlling, or eliminating air or water pollution. Pollution control equipment does not include any apparatus used to eliminate noise pollution. Liquid, solid, and gaseous wastes are included within the meaning of the word “pollution.” Pollution control equipment specifically includes, but is not limited to, any equipment the use of which is required or certified by an agency of this state or of the United States government. Wastewater treatment equipment, dust mitigation systems, and scrubbers used in smokestacks are examples of pollution control equipment. However, pollution control equipment does not include any equipment used only for worker safety, such as a gas mask.

EXAMPLE: A manufacturer constructs a wastewater treatment facility to treat wastewater from its manufacturing facility. The wastewater treatment facility uses aboveground piping and other equipment to divert wastewater from the local water treatment plant. The facility then converts wastewater into a biogas, which the manufacturer uses as an energy source in its manufacturing facility. The equipment used for the wastewater treatment facility is pollution control equipment used by a manufacturer. The sales price of the equipment is exempt from sales and use tax.

This rule is intended to implement Iowa Code section 423.3(47) “a”(6).  
[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.21(423) Exemption for the sale of fuel or electricity used in exempt property if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price of fuel or electricity consumed by property that is exempt from sales and use tax under rule 701—230.14(423), 701—230.15(423), 701—230.16(423), 701—230.17(423), 701—230.19(423), or 701—230.20(423) is also exempt from sales and use tax. The sales price of electricity or other fuel consumed by computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise remains subject to tax even if such computers are exempt under rule 701—230.18(423). For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

EXAMPLE: A manufacturer operates a power plant. The manufacturer uses energy from the power plant to operate machinery and equipment used directly and primarily in processing at its manufacturing facility. The fuel consumed in the manufacturer’s power plant is exempt from sales and use tax.

This rule is intended to implement Iowa Code section 423.3(47) “b.”  
[ARC 2349C, IAB 1/6/16, effective 2/10/16]

**701—230.22(423) Exemption for the sale of services for designing or installing new industrial machinery or equipment if the sale occurs as part of a contract entered into on or after July 1, 2016.** The sales price from the services of designing or installing new industrial machinery or equipment is exempt from sales and use tax. The enumerated services of electrical or electronic installation are included in this exemption.

**230.22(1)** Required elements. To qualify for the exemption, the purchaser must prove the service is:

- a. A design or installation service (see subrule 230.22(2));
- b. Of new (see subrule 230.22(3)); and
- c. Industrial machinery or equipment (see subrule 230.22(4)).

**230.22(2)** Design or installation services include electrical and electronic installation. “Design or installation” services do not include any repair service.

**230.22(3)** “New” means never having been used or consumed by anyone. The exemption does not apply to design or installation services on reconstructed, rebuilt, repaired, or previously owned machinery or equipment.

**230.22(4)** Industrial machinery or equipment.

*a. Generally.* “Industrial machinery or equipment” means machinery or equipment, as defined in subrule 230.14(2). The sale of industrial machinery or equipment must also qualify for exemption under any of the following:

(1) Property used directly and primarily in processing by a manufacturer (see rule 701—230.15(423)).

(2) Property used directly and primarily by a manufacturer to maintain the integrity of the manufacturer’s product or to maintain unique environmental conditions for computers, machinery, or equipment (see rule 701—230.16(423)).

(3) Property used directly and primarily in research and development of new products or processes of processing (see rule 701—230.17(423)).

(4) Property used directly and primarily in recycling or reprocessing of waste products (see rule 701—230.19(423)).

(5) Pollution control equipment used by a manufacturer (see rule 701—230.20(423)).

*b. Exclusions.* The following property is not industrial machinery or equipment regardless of how the purchaser uses it:

(1) Computers (see paragraph 230.14(2) “a”).

(2) Supplies, including but not limited to drill bits, grinding wheels, punches, taps, reamers, saw blades, lubricants, coolants, sanding discs, sanding belts, and air filters.

(3) Replacement parts (see paragraph 230.14(2) “d”).

**230.22(5) Billing.** The sales price for designing or installing new industrial machinery or equipment must be separately identified, charged separately, and reasonable in amount for the exemption to apply. The exemption applies to new industrial machinery or equipment regardless of how it is purchased, including leased or rented machinery or equipment.

**EXAMPLE:** Dealer sells and installs two new machines for Manufacturer. Manufacturer uses one machine on its production floor, where it is directly and primarily used in processing. Manufacturer uses the other machine in its machine shop, where it is not directly and primarily used in processing. Dealer gives an invoice to Manufacturer that separately itemizes the sales prices for each machine and each installation. The machine used on the production floor is new industrial machinery or equipment, and the sales prices of the machine and its installation are exempt from sales and use tax. The machine used in the machine shop is not new industrial machinery or equipment, and the sales prices of the machine and its installation are taxable.

This rule is intended to implement Iowa Code section 423.3(48).

[ARC 2349C, IAB 1/6/16, effective 2/10/16]

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[Filed ARC 2349C (Amended Notice ARC 2239C, IAB 11/11/15; Notice ARC 2178C, IAB 9/30/15), IAB 1/6/16, effective 2/10/16]



CHAPTER 602  
CLASSES OF DRIVER'S LICENSES

**761—602.1(321) Driver's licenses.**

**602.1(1) *Classes.*** The department issues the following classes of driver's licenses. All licenses issued, including special licenses and permits, shall carry a class designation. A license shall be issued for only one class, except that Class M may be issued in combination with another class.

- Class A—commercial driver's license (CDL)
- Class B—commercial driver's license (CDL)
- Class C—commercial driver's license (CDL)
- Class C—noncommercial driver's license
- Class D—noncommercial driver's license (chauffeur)
- Class M—noncommercial driver's license (motorcycle)

**602.1(2) *Special licenses and permits.*** The department issues the following special licenses and permits. More than one type of special license or permit may be issued to an applicant. On the driver's license, a restriction number designates the type of special license or permit issued, as follows:

- 1—Motorcycle instruction permit—includes motorcycle instruction permits issued under Iowa Code subsections 321.180(1) and 321.180B(1)
- 2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)—includes instruction permits, other than motorcycle instruction permits, issued under Iowa Code subsection 321.180(1) and section 321.180A and subsection 321.180B(1)
- 3—Commercial learner's permit
- 4—Chauffeur's instruction permit
- 5—Motorized bicycle license
- 6—Minor's restricted license
- 7—Minor's school license

**602.1(3) *Commercial driver's license (CDL).*** See 761—Chapter 607 for information on the procedures, requirements and validity of a commercial driver's license (Classes A, B and C) and a commercial learner's permit, and their restrictions and endorsements.

This rule is intended to implement Iowa Code sections 321.178, 321.180, 321.180A, 321.180B, 321.189, and 321.194.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—602.2(321) Information and forms.** Applications, forms and information about driver's licensing are available at any driver's license examination station. Assistance is also available at the address in rule 761—600.2(17A).

**602.2(1) *Certificate of completion.*** Form 430036 shall be used to submit proof of successful completion of an Iowa-approved course in driver education, motorcycle rider education or motorized bicycle education.

*a.* If a student completed a course in another state, a public or licensed commercial or private provider of the Iowa-approved course may issue the form for the student if the provider determines that the out-of-state course is comparable to the Iowa-approved course.

*b.* If the out-of-state course is comparable but lacks certain components of the Iowa-approved course, the provider may issue the form after the student completes the missing components.

**602.2(2) *Affidavit for school license.*** Form 430021 shall be used for submitting the required statements, affidavits and parental consent for a minor's school license. See rule 761—602.26(321).

**602.2(3) *Waiver of accompanying driver for intermediate licensee.*** Form 431170 is the waiver described in Iowa Code subsection 321.180B(2). This form allows an intermediate licensee to drive unaccompanied between the hours of 12:30 a.m. and 5 a.m. and must be in the licensee's possession when the licensee is driving during the hours to which the waiver applies.

- a.* If the waiver is for employment, the form must be signed by the licensee's employer.

*b.* If the waiver is for school-related extracurricular activities, the form must be signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent.

*c.* The form must be signed by the licensee's parent or guardian. However, the parent's or guardian's signature is not required if the licensee is married and the original or a certified copy of the marriage certificate is in the licensee's possession when the licensee is driving during the hours to which the waiver applies.

This rule is intended to implement Iowa Code sections 321.8, 321.178, 321.180B, 321.184, 321.189, and 321.194.

[ARC 7902B, IAB 7/1/09, effective 8/5/09]

**761—602.3(321) Examination and fee.** Rescinded IAB 8/9/00, effective 7/24/00.

**761—602.4(321) Definitions of immediate family.**

**602.4(1)** A "member of the permittee's immediate family" as used in Iowa Code subsection 321.180(1) means the permittee's parent or guardian or a brother, sister or other relative of the permittee who resides at the permittee's residence.

**602.4(2)** A "member of the permittee's immediate family" as used in Iowa Code section 321.180B, subsections 1 and 2, means a brother, sister or other relative of the permittee who resides at the permittee's residence.

This rule is intended to implement Iowa Code sections 321.180 and 321.180B.

**761—602.5 to 602.10** Reserved.

**761—602.11(321) Class C noncommercial driver's license.** This rule describes a noncommercial Class C driver's license that is not a special license or permit.

**602.11(1) *Validity and issuance.***

*a.* The license is valid for operating:

(1) A motor vehicle that does not require a commercial driver's license or a Class D driver's license for its operation.

(2) A motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

*b.* The license is issued for either two years or eight years.

(1) A qualified applicant who is at least 17 years, 11 months of age but not yet 72 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee's 74th birthday.

(2) A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 72 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

**602.11(2) *Requirements.***

*a.* An applicant shall be at least 16 years of age.

*b.* Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.

This rule is intended to implement Iowa Code sections 321.177, 321.178, 321.180B, 321.189, and 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14]

**761—602.12(321) Class D noncommercial driver's license (chauffeur).** This rule describes a noncommercial Class D driver's license.

**602.12(1) *Validity and issuance.***

*a.* The license is valid for operating:

(1) A motor vehicle as a chauffeur as specified by the endorsement on the license, unless the type of vehicle or type of operation requires a commercial driver's license.

(2) A motor vehicle that may be legally operated under a noncommercial Class C driver's license, including a motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

*b.* The license shall have one endorsement authorizing a specific type of motor vehicle or type of operation, as listed in 761—subrule 605.4(3). The gross vehicle weight rating shall be determined pursuant to rule 761—604.35(321).

*c.* The license is issued for either two years or eight years.

(1) A qualified applicant who is at least 18 years of age but not yet 72 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee's 74th birthday.

(2) A two-year license shall be issued to a qualified applicant who is 72 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

**602.12(2) Requirements.**

*a.* An applicant shall be at least 18 years of age.

*b.* Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177, 321.189, and 321.196. [ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—602.13(321) Class M noncommercial driver's license (motorcycle).** This rule describes a noncommercial Class M driver's license that is not a special license or permit.

**602.13(1) Validity and issuance.**

*a.* The license is valid for operating:

(1) A motorcycle. However, the license may have a restriction which limits operation to a three-wheel motorcycle.

(2) A motorized bicycle.

*b.* The license is issued for either two years or eight years.

(1) A qualified applicant who is at least 17 years, 11 months of age but not yet 72 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee's 74th birthday.

(2) A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 72 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

*c.* An Iowa driver's license issued before March 15, 1968, which is still valid because of an extension, is valid for motorcycles. An Iowa driver's license issued from March 15, 1968, through June 30, 1972, which is still valid because of an extension, is valid for motorcycles unless the back of the license is stamped "Not valid for motorcycles."

**602.13(2) Requirements.**

*a.* An applicant shall be at least 16 years of age.

*b.* Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.

*c.* An applicant under 18 years of age must submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 321.177, 321.178, 321.180B, 321.189 and 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14]

**761—602.14(321) Transition from five-year to eight-year licenses.** During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department's computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

This rule is intended to implement Iowa Code section 321.196 and 2013 Iowa Acts, chapter 104, section 2.

[ARC 1714C, IAB 11/12/14, effective 12/17/14]

**761—602.15(321) Minor's restricted license.** Renumbered as 761—602.25(321)IAB 1/8/92, effective 2/12/92.

**761—602.16(321) Temporary instruction permit.** Rescinded IAB 1/8/92, effective 2/12/92.

**761—602.17(321) Minor's school license.** Renumbered as 761—602.26(321)IAB 1/8/92, effective 2/12/92.

**761—602.18(321) Motorcycle instruction permit.** This rule describes a motorcycle instruction permit issued under Iowa Code subsection 321.180(1) or 321.180B(1).

**602.18(1) Validity and issuance.**

- a. The motorcycle instruction permit is a permit that is added to another driver's license.
- b. The permit is valid for operating a motorcycle when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.
- c. The permit is not valid for operating a motorized bicycle.
- d. The permit is issued for four years and is not renewable.

**602.18(2) Requirement.** An applicant shall be at least 14 years of age.

This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

**761—602.19(321) Noncommercial instruction permit.** This rule describes a noncommercial instruction permit, other than a motorcycle instruction permit, issued under Iowa Code subsection 321.180(1) or 321.180B(1).

**602.19(1) Validity and issuance.**

- a. The permit is a restricted, noncommercial Class C driver's license.
- b. The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver's license when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.
- c. The permit is not valid for operating a motorized bicycle.
- d. The permit is not valid as a motorcycle instruction permit.
- e. The permit is issued for four years.

**602.19(2) Requirement.** An applicant shall be at least 14 years of age.

This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

**761—602.20** Rescinded IAB 11/18/98, effective 12/23/98.

**761—602.21(321) Special noncommercial instruction permit.** This rule describes a special noncommercial instruction permit issued under Iowa Code section 321.180A.

**602.21(1) Validity and issuance.**

- a. The permit is a restricted, noncommercial Class C driver's license that is issued to a person whose application for driver's license renewal has been denied or whose driver's license has been suspended for incapability due to a physical disability.

*b.* The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver's license when the permittee is accompanied by a person specified in Iowa Code section 321.180A.

*c.* The permit is not valid for operating a motorized bicycle.

*d.* The permit is not valid as a motorcycle instruction permit.

*e.* The permit is valid for six months from the date of issuance. It is invalid after the expiration date on the permit.

*f.* The permit may be reissued for one additional six-month period.

**602.21(2) Requirement.** An applicant must submit a medical report pursuant to 761—subrule 600.4(6).

This rule is intended to implement Iowa Code section 321.180A.

**761—602.22** Reserved.

**761—602.23(321) Chauffeur's instruction permit.**

**602.23(1) Validity and issuance.**

*a.* A chauffeur's instruction permit is a permit that is added to a Class D license or a noncommercial Class C license that is not a special license or permit.

*b.* The license with the permit is valid for operating:

(1) A motor vehicle that may be legally operated under the class of license (and for Class D, the endorsement) held by the licensee, including a motorized bicycle.

(2) A motor vehicle, other than a commercial motor vehicle or a motorcycle, as a chauffeur if accompanied by a person with a valid Class D license or a commercial driver's license valid for the vehicle being operated.

*c.* The permit is issued for two years.

**602.23(2) Requirements.**

*a.* An applicant shall be at least 18 years of age.

*b.* Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177 and 321.180.

**761—602.24(321) Motorized bicycle license.**

**602.24(1) Validity and issuance.**

*a.* A motorized bicycle license is a restricted, noncommercial Class C license.

*b.* The license is valid for operating a motorized bicycle.

*c.* The license is issued for two years.

**602.24(2) Requirements.**

*a.* An applicant shall be at least 14 years of age.

*b.* An applicant under 16 years of age must submit proof of successful completion of an Iowa-approved course in motorized bicycle education.

This rule is intended to implement Iowa Code sections 321.177 and 321.189.

**761—602.25(321) Minor's restricted license.**

**602.25(1) Validity and issuance.**

*a.* A minor's restricted license is a restricted, noncommercial Class C or Class M driver's license.

*b.* The license is valid for driving to and from the licensee's place of employment or to transport dependents to and from temporary care facilities, if necessary to maintain the licensee's present employment.

*c.* The type of motor vehicle that may be operated is controlled by the class of driver's license issued. A Class C minor's restricted license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor's restricted license is valid for operating a motorized bicycle only for the purposes specified in paragraph "b" of this subrule.

*d.* The license is issued for two years.

**602.25(2) Requirements.**

- a. The applicant shall be at least 16 years of age but not yet 18.
- b. The applicant shall submit to the department a statement from the employer confirming the applicant's employment.
- c. Proof of nonattendance is required. Proof of nonattendance is receipt of notification from the appropriate school authority that the applicant does not attend school, as set out in 761—subrule 615.23(2).
- d. The applicant shall submit proof of successful completion of an Iowa-approved course in driver education.
- e. For a Class M minor's restricted license or a motorcycle endorsement, the applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 299.1B, 321.178, 321.180B, 321.189, 321.196 and 321.213B.

**761—602.26(321) Minor's school license.****602.26(1) Validity and issuance.**

- a. A minor's school license is a restricted, noncommercial Class C or Class M driver's license.
- b. The license is valid for driving unaccompanied from 6 a.m. to 10 p.m. on the most direct route between a licensee's residence and schools of enrollment or the closest school bus stop or public transportation service, and between schools of enrollment, to attend scheduled courses and extracurricular activities within the school district.
- c. The license is also valid for driving when the licensee is accompanied by a person specified in Iowa Code subsection 321.180B(1).
- d. The type of motor vehicle that may be operated is controlled by the class of driver's license issued. A Class C minor's school license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor's school license is valid for operating a motorized bicycle only for the purposes specified in paragraph "b" of this subrule.
- e. The license is issued for two years.

**602.26(2) Requirements.**

- a. An applicant shall be at least 14 years of age but not yet 18 and meet the requirements of Iowa Code section 321.194.
- b. An applicant shall submit a statement of necessity signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent. The statement shall be on Form 430021.
- c. An applicant shall submit proof of successful completion of an Iowa-approved course in driver education.
- d. For a Class M minor's school license or a motorcycle endorsement, an applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

**602.26(3) Exemption.**

a. An applicant is not required to have completed an approved driver education course if the applicant demonstrates to the satisfaction of the department that completion of the course would impose a hardship upon the applicant; however, the applicant must meet all other requirements for a school license. "Hardship" means:

(1) If the applicant is 14 years old, that a driver education course will not begin at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence within one year following the applicant's fourteenth birthday; or

(2) If the applicant is 15 years old, that a driver education course will not begin at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence within six months following the applicant's fifteenth birthday; or

(3) If the applicant is between 16 and 18 years old, that a driver education course is not offered at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence at the time the request for hardship status is submitted to the department; or

(4) That the applicant is permanently handicapped. In this rule, “handicapped” means that, because of a disability or impairment, the applicant is unable to walk in excess of 200 feet unassisted or cannot walk without causing serious detriment or injury to the applicant’s health.

*b.* “Demonstrates to the satisfaction of the department” means that the department has received an affidavit on Form 430021 attesting that completion of the course would impose a hardship upon the applicant. The affidavit shall be signed by the applicant’s parent, custodian or guardian and by the superintendent of the applicant’s school, the chairperson of the school board, or the principal of the applicant’s school if authorized by the superintendent.

This rule is intended to implement Iowa Code sections 321.177, 321.180B, 321.189, 321.194 and 321.196.

**761—602.27 to 602.29** Reserved.

**761—602.30(321) Special instruction permit.** Rescinded IAB 1/8/92, effective 2/12/92.

[Filed 1/20/88, Notice 12/2/87—published 2/10/88, effective 3/16/88]<sup>1</sup>

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<sup>1</sup> Effective date delayed 70 days by the Administrative Rules Review Committee at its March 9, 1988, meeting. Delay lifted by ARRC, April 21, 1988.



CHAPTER 604  
LICENSE EXAMINATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C)rules 13.3 and 13.17]

**761—604.1(321) Authority and scope.**

**604.1(1)** The department is authorized to determine by examination an applicant's ability to operate motor vehicles safely upon the highways and to issue all driver's licenses.

**604.1(2)** This chapter of rules shall apply to the examination for all driver's licenses. Information on the additional examination procedures and requirements for a commercial driver's license or commercial learner's permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code sections 321.2, 321.3, 321.13, 321.177, and 321.186. [ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—604.2(321) Definitions.**

*"Binocular field of vision"* is the sum of the temporal measurements or the sum of the nasal measurements.

*"Monocular field of vision"* is the sum of the temporal measurement and the nasal measurement for one eye.

*"Representative vehicle"* is a vehicle which is characteristic of and requires operating skills comparable to those vehicles that may legally be operated under the class of license or endorsement desired.

This rule is intended to implement Iowa Code sections 321.174 and 321.186. [ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.3(17A) Information and forms.**

**604.3(1)** Applications, forms, and information about driver's license examinations are available at any driver's license examination station. Assistance is also available from the office of driver services at the address in 761—600.2(17A).

**604.3(2)** The "Iowa Driver Manual" and the "Iowa Motorcycle Operator Manual" are also available from the department.

This rule is intended to implement Iowa Code section 17A.3.

**761—604.4 to 604.6** Reserved.

**761—604.7(321) Examination.**

**604.7(1)** An examination shall include:

- a. A vision screening if the person has not filed a vision report.
- b. A knowledge test of Iowa traffic laws and highway signs.
- c. A driving test of the person's ability to operate a motor vehicle.

**604.7(2)** The examination required for a driver's license depends upon the class of license requested, applicable endorsements, and the qualifications of the applicant.

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

**761—604.8 and 604.9** Reserved.

**761—604.10(321) Vision screening.**

**604.10(1) Requirement.** Vision screening or a vision report is required of an applicant for a driver's license.

**604.10(2) Method.** At driver's license examination stations, a vision screening instrument shall be used to screen the applicant's vision. An applicant who has corrective lenses may be screened with or without the corrective lenses.

**604.10(3) Report.** A vision report shall be submitted on Form 430032 signed by a licensed vision specialist and shall report the person's visual acuity level and field of vision as measured within 30 days prior to the date of the application. In lieu of Form 430032, a vision report signed by a licensed vision

specialist on the specialist's letterhead may be accepted if it contains all the information specified on Form 430032.

**604.10(4) Exception for persons renewing electronically.** An applicant renewing a driver's license electronically pursuant to 761—subrule 605.25(7) is not required to complete a vision screen or submit a vision report to complete the renewal. This subrule does not preclude the department from requiring a vision screen or vision report of a person who has renewed a driver's license electronically when the department has reason to believe that the person is not capable of operating a motor vehicle safely.

This rule is intended to implement Iowa Code sections 321.186, 321.186A and 321.196 as amended by 2013 Iowa Acts, House File 355, section 1.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13]

**761—604.11(321) Vision standards.** The visual acuity and field of vision standards for licensing and the applicable restrictions are as follows.

**604.11(1) Visual acuity standards.**

*a. When the applicant is screened without corrective lenses.* If the visual acuity is 20/40 or better with both eyes or with the better eye, no restriction will be imposed. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be restricted from driving when headlights are required.

*b. When the applicant is screened with corrective lenses.* If the visual acuity is 20/40 or better with both eyes or with the better eye, the applicant shall be required to wear corrective lenses. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be required to wear corrective lenses and shall be restricted from driving when headlights are required.

*c. Other standards.* If the visual acuity in the left eye is less than 20/100, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors. However, if the applicant has a visual acuity of 20/40 in the right eye and less than 20/100 in the left eye without corrective lenses and has corrective lenses that improve the vision in the left eye to better than 20/100, the applicant shall have the option of being restricted to driving with corrective lenses or driving a vehicle with both left and right outside rearview mirrors.

**604.11(2) Field of vision standards.**

*a.* If the binocular field of vision is at least 140 degrees, no restriction will be imposed.

*b.* If the binocular field of vision is less than 140 degrees but at least 110 degrees, or one eye has a monocular field of vision of at least 100 degrees, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors.

This rule is intended to implement Iowa Code sections 321.186, 321.193, and 321.196.

[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.12(321) Vision referrals.**

**604.12(1) Referral.**

*a.* If an applicant on first screening cannot attain 20/40 but can attain 20/70 with at least one eye, the department shall not issue a license to the applicant. Instead, the department shall advise the applicant to consult a licensed vision specialist.

*b.* A vision report, pursuant to subrule 604.10(3), shall be required before the department will reconsider licensing.

**604.12(2) License.**

*a.* The department shall affix a sticker to the applicant's license stating: "Renewal or license issuance denied due to vision."

*b.* If the applicant's license is valid for less than 30 days, the department may issue a temporary driving permit with restrictions appropriate to the applicant's visual acuity level and field of vision. The temporary driving permit is valid for not more than 30 days from the end of the current license validity.

**604.12(3) Report.** If the vision report recommends a restriction, the department shall issue a restricted license even though it would not be required by departmental standards.

**604.12(4) Applicant refusal.** If an applicant refuses to consult a licensed vision specialist, the department shall issue or deny the license based on the results achieved on the vision screening.

This rule is intended to implement Iowa Code sections 321.181, 321.186, 321.186A, 321.193 and 321.196.

**761—604.13(321) Vision screening results.**

**604.13(1) Two-year license.** An applicant who cannot attain a visual acuity of 20/40 with both eyes or with the better eye shall be issued a two-year license. This restriction may be waived by the department when a vision report pursuant to subrule 604.10(3) certifies that the vision has stabilized and is not expected to deteriorate.

**604.13(2) License denied.**

*a.* An applicant who cannot attain a visual acuity of 20/70 with both eyes or with the better eye shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

*b.* If the applicant's binocular field of vision is less than 110 degrees, or the monocular field of vision is less than 100 degrees, the applicant shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

**604.13(3) Reapplication.** An applicant who cannot meet the vision standards in subrule 604.13(2) may reapply when the vision improves and meets the vision standards. If a suspension or denial notice was served, reapplication must be made to the office of driver services at the address in 761—600.2(17A), and not at a driver's license examination station.

**604.13(4) Discretionary issuance.**

*a.* An applicant whose license is restricted under rule 761—604.11(321) or who cannot meet the vision standards in subrule 604.13(2) may submit a written request for review by an informal settlement officer.

*b.* Based upon consideration of the applicant's vision screening results or vision report, driving test and driving record, the written recommendation of the applicant's licensed vision specialist, and traffic conditions in the vicinity of the applicant's residence, the officer may recommend issuing a license with restrictions suitable to the applicant's capabilities. However:

(1) An applicant who cannot attain a visual acuity of 20/100 with both eyes or with the better eye may be considered for licensing only after recommendation by the medical advisory board.

(2) An applicant who cannot attain a visual acuity of 20/199 with both eyes or with the better eye shall not be licensed.

(3) If an applicant's binocular field of vision or monocular field of vision is less than 75 degrees, the applicant may be considered for licensing only after recommendation by the medical advisory board.

(4) An applicant who cannot attain a binocular or monocular field of vision of 21 degrees shall not be licensed.

*c.* The officer's recommendation denying discretionary issuance or regarding the extent and nature of restrictions is subject to reversal or modification upon review or appeal only if it is clearly characterized by an abuse of discretion.

This rule is intended to implement Iowa Code sections 321.186, 321.186A, 321.193 and 321.196.  
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.14 to 604.19** Reserved.

**761—604.20(321) Knowledge test.**

**604.20(1) Written test.** A knowledge test is a written test to determine an applicant's ability to read and understand Iowa traffic laws and the highway signs that regulate, warn, and direct traffic. A test may be revised at any time but each test states the minimum passing score.

**604.20(2) Three types of tests.** There are three types of knowledge tests: an operator's test, a chauffeur's test, and a motorcycle test. The requirement for a license depends upon the class of license desired, applicable endorsements, and the qualifications of the applicant.

**604.20(3) Oral test.** An applicant who is unable to read or understand a written test may request an oral test. The oral test may be administered by an examiner or by an automated testing device.

**604.20(4) Waiver.** Rescinded IAB 1/8/92, effective 2/12/92.

This rule is intended to implement Iowa Code section 321.186.

**761—604.21(321) Knowledge test requirements and waivers.**

**604.21(1) Knowledge test requirements.** The knowledge test requirements are as follows:

*a. Operator's test.* An operator's knowledge test is required for all classes of driver's licenses and all types of special driver's licenses and permits.

*b. Motorcycle test.* A motorcycle knowledge test is required for all:

- (1) Motorcycle instruction permits.
- (2) Class M driver's licenses.
- (3) Motorcycle endorsements.

*c. Chauffeur's test.* A chauffeur's knowledge test is required for all:

- (1) Chauffeur's instruction permits.
- (2) Class D driver's licenses except those with an endorsement for "passenger vehicle less than 16-passenger design."

**604.21(2) Knowledge test waivers.** The department may waive a knowledge test listed in subrule 604.21(1) if the applicant meets one of the following qualifications:

*a.* The applicant has passed the same type of test for another Iowa driver's license or an equivalent out-of-state license that is still valid.

*b.* The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

*c.* The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

This rule is intended to implement Iowa Code sections 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.196 and 321.198.

**761—604.22(321) Knowledge test results.**

**604.22(1) Proof of Passing score.** When necessary, the department shall give the applicant a form, valid for 90 days, which certifies that the applicant has passed the knowledge test.

**604.22(2) Retesting.** An applicant who fails a knowledge test may repeat the test at the discretion of the examiner, but at least two hours shall elapse between tests.

This rule is intended to implement Iowa Code section 321.186.

**761—604.23 to 604.29** Reserved.

**761—604.30(321) Driving test.** A driving test is a demonstration of an applicant's ability to exercise ordinary and reasonable control in the operation of a motor vehicle under actual traffic conditions. The test is also called a road test, field test, or driving demonstration. A motorcycle skill test is an off-street demonstration of an applicant's ability to control the motorcycle in a set of standard maneuvers, and a motorcycle driving test is an on-street demonstration.

**604.30(1) Vehicle type and safety.**

*a.* For the driving test, the applicant shall provide a representative vehicle as defined in 761—604.2(321).

*b.* The examiner or other authorized personnel shall visually inspect the vehicle. If a vehicle is illegal or unsafe, or is not a representative vehicle, the examiner shall refuse to administer the test until corrections are made or an acceptable vehicle is provided.

**604.30(2) Criteria and route.** Form 430024, "Your Driving Test," explains the criteria for passing the test and shall be given to the applicant before any required test, except a motorcycle skill test. The applicant shall be directed over one of the routes which have been preselected by the examiner to test driving skills and maneuvers.

**604.30(3) Test score.** The examiner shall use the standard departmental score sheet and shall enter the test score and the licensing decision in the spaces provided. At the end of the test, the examiner shall explain the test score. The test score result is valid for 90 days.

**604.30(4) Retesting.** If an applicant fails a driving test, the test may be rescheduled at the discretion of the examiner.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.  
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.31(321) Driving test requirements and waivers for noncommercial driver's licenses.**

**604.31(1) Driving test requirements.** The driving test requirements for noncommercial driver's licenses are as follows:

- a. *Instruction permits.* A driving test is not required to obtain an instruction permit.
- b. *Class C driver's licenses.* For a Class C driver's license other than an instruction permit or a motorized bicycle license, an operator's driving test in a representative vehicle is required.
- c. *Class D driver's licenses.* For a Class D driver's license, a driving test in a representative vehicle for the endorsement requested, as set out in 761—subrule 605.4(3), is required.
- d. *Class M driver's licenses and motorcycle endorsements.* The driving test for a Class M driver's license or motorcycle endorsement consists of two parts: an off-street motorcycle skill test and an on-street driving test.

(1) The off-street motorcycle skill test is required. The on-street motorcycle driving test is also required if the applicant does not have another driver's license that permits unaccompanied driving.

(2) A motorcycle shall be used for these tests. If a three-wheeled motorcycle is used, the driver's license shall be restricted: "Not valid for 2-wheel vehicle."

e. *Motorized bicycle licenses.* For a motorized bicycle license, an off-street or on-street driving test may be required. A motorized bicycle shall be used for the test.

**604.31(2) Driving test waivers.** The department may waive a required driving test listed in subrule 604.31(1) if the applicant meets one of the following qualifications:

a. The applicant is applying for the applicant's first Iowa driver's license that permits unaccompanied driving following successful completion of the appropriate Iowa-approved course or courses. The appropriate Iowa-approved courses are the following: driver education, other than driver education by a teaching parent under rule 761—634.11(321), for a Class C driver's license other than motorized bicycle; driver education and motorcycle rider education for a Class M driver's license or motorcycle endorsement; and motorized bicycle education for a motorized bicycle license. However, if an applicant is under the age of 18, a driving test is required if so requested by the applicant's parent, guardian, or instructor.

b. The applicant is renewing a Class C, Class D or Class M Iowa driver's license or endorsement within 14 months after the expiration date.

c. The applicant has passed the same type of driving test for another Iowa driver's license or endorsement that is still valid or has expired within the past 14 months.

d. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

e. The applicant is applying for a Class C Iowa driver's license that permits unaccompanied driving and has an equivalent out-of-state license that is valid or has expired within the past year.

f. The applicant is applying for a Class D Iowa driver's license and has an equivalent out-of-state license that is valid or has expired within the past year.

g. The applicant is applying for a Class M driver's license or a motorcycle endorsement and has an equivalent out-of-state Class M driver's license or motorcycle endorsement that is valid or has expired within the past year.

*h.* The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

This rule is intended to implement Iowa Code sections 321.174, 321.178, 321.178A, 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.193, 321.196 and 321.198.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 1612C, IAB 9/3/14, effective 10/8/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—604.32(321) Driving tests requirements.** Rescinded IAB 1/8/92, effective 2/12/92.

**761—604.33 and 604.34** Reserved.

**761—604.35(321) Determination of gross vehicle weight rating.** For a vehicle that has no legible manufacturer's certification label, the applicant may provide documentation of the gross vehicle weight rating, such as a manufacturer's certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

This rule is intended to implement Iowa Code section 321.1.

**761—604.36 to 604.39** Reserved.

**761—604.40(321) Failure to pass examination.**

**604.40(1)** An applicant who fails to pass a required examination or reexamination shall not be licensed.

*a.* If the applicant does not have a valid Iowa license, the department shall deny the applicant a license.

*b.* If the applicant has a valid Iowa license, the department shall suspend the license for incapability. However, if the applicant's license is valid for less than 30 days, the department shall deny further licensing. The department shall serve a notice of suspension or denial.

*c.* See 761—615.4(321) for further information on denials and 761—615.14(321) for further information on suspensions for incapability.

*d.* An applicant may contest a denial or suspension in accordance with 761—615.38(321).

**604.40(2)** Limitations on the hearing and appeal process.

*a.* After a suspension or denial for failure to pass a required knowledge or driving test, a person who contests the suspension or denial shall be deemed to have exhausted the person's administrative remedies after three unsuccessful attempts to pass the required test.

*b.* After the three unsuccessful attempts, no further testing shall be allowed until six months have elapsed from the date of the last test failure, and then only if the applicant demonstrates a significant change or improvement in those physical or mental factors that resulted in the original decision. A request for further testing must be submitted in writing to the office of driver services at the address in rule 761—600.2(17A).

*c.* Notwithstanding paragraphs "a" and "b" of this subrule, no testing shall occur if the director determines that it is unsafe to allow testing.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177, 321.180A and 321.210.

**761—604.41 to 604.44** Reserved.

**761—604.45(321) Reinstatement.** A person whose license has been suspended or denied for failure to pass a required examination or reexamination shall meet the vision standards for licensing, pass the required knowledge examination(s), and pass the required driving test(s) before an Iowa license will be issued.

This rule is intended to implement Iowa Code sections 321.177 and 321.186.

**761—604.46 to 604.49** Reserved.

**761—604.50(321) Special reexaminations.** The department may require a special reexamination consisting of a vision screening, knowledge test and driving test of any licensee.

**604.50(1)** The department may require a special reexamination when a licensee has been involved in a fatal motor vehicle accident and the investigating officer's report of the accident indicates the licensee contributed to the accident.

**604.50(2)** The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officer's report of each accident lists one of the following "Driver/Vehicle Related Contributing Circumstances" for the licensee:

- a. Ran traffic signal.
- b. Ran stop sign.
- c. Passing, interfered with other vehicle.
- d. Left of center, not passing.
- e. Failure to yield right-of-way at uncontrolled intersection.
- f. Failure to yield right-of-way from stop sign.
- g. Failure to yield right-of-way from yield sign.
- h. Failure to yield right-of-way making left turn.
- i. Failure to yield right-of-way to pedestrian.
- j. Failure to have control.

**604.50(3)** The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officers' reports for both accidents list a driver condition for the licensee of "apparently asleep."

**604.50(4)** The department may require a special reexamination when a licensee who is 65 years of age or older has been involved in an accident and information in the investigating officer's or the person's own report of the accident indicates the need for reexamination. A circumstance that may indicate a need for reexamination includes, but is not limited to, any one of the following:

- a. The licensee made a left turn that resulted in the accident.
- b. The licensee failed to yield the right-of-way at a stop sign.
- c. The licensee failed to yield the right-of-way at a yield sign.
- d. The licensee failed to yield the right-of-way at an uncontrolled intersection.
- e. The licensee failed to yield the right-of-way at a traffic control signal.
- f. The licensee's vision may be a contributing factor to a nighttime accident.
- g. The licensee has a physical disability-related license restriction other than "corrective lenses" and the accident involved one of the circumstances listed in paragraphs "a" to "f" above.

**604.50(5)** The department may require a special reexamination when recommended by a peace officer, a court, or a properly documented citizen's request. A factor that may indicate a need for reexamination includes, but is not limited to, any one of the following:

- a. Loss of consciousness.
- b. Confusion, disorientation or dementia.
- c. Inability to maintain a vehicle in the proper lane.
- d. Repeatedly ignoring traffic control devices in a nonchase setting.
- e. Inability to interact safely with other vehicles.
- f. Inability to maintain consistent speed when no reaction to other vehicles or pedestrians is required.

This rule is intended to implement Iowa Code sections 321.177, 321.186 and 321.210.

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<sup>1</sup> Effective date of 604.11(2) and 604.13(2) “b” delayed until adjournment of the 1988 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its June 1987 meeting.

CHAPTER 605  
LICENSE ISSUANCE

**761—605.1(321) Scope.** This chapter of rules applies to the issuance of all Iowa driver's licenses. Additional information on the issuance of a commercial driver's license or a commercial learner's permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code section 321.174.  
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—605.2(321) Contents of license.** In addition to the information specified in Iowa Code subsection 321.189(2), the following information shall be shown on a driver's license.

**605.2(1) Name.** The licensee's full legal name shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(5) and shall conform to the requirements of 761—subrule 601.1(2).

**605.2(2) Current residential address.** The licensee's current residential address shall be listed as established according to the requirements of 761—subrule 601.5(3).

**605.2(3) Physical description.** The physical description of the licensee on the face of the driver's license shall include:

*a.* The licensee's eye color using these abbreviations: Blk-black, Blu-blue, Bro-brown, Gry-gray, Grn-green, Haz-hazel, and Pnk-pink.

*b.* The licensee's height in inches.

**605.2(4) Date of birth.** The licensee's date of birth shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(6).

**605.2(5) Sex.** The licensee's sex designation shall be listed as established according to the requirements of 761—subrule 601.5(7).

**605.2(6) REAL ID markings.**

*a.* A driver's license that is issued as a REAL ID license as defined in 761—601.7(321) shall include a security marking as required by 6 CFR 37.17(n).

*b.* Beginning January 15, 2013, a driver's license that is not issued as a REAL ID license as defined in 761—601.7(321) may be marked as required by 6 CFR 37.71 and any subsequent guidance issued by the U.S. Department of Homeland Security.

*c.* A driver's license issued to a foreign national with temporary lawful status shall include the following statement on the face of the license: "limited term."

**605.2(7) Voluntary markings.** Upon the request of the licensee, the department shall indicate on the driver's license the presence of a medical condition, that the licensee is a donor under the uniform anatomical gift law, that the licensee has in effect a medical advance directive, that the licensee is hearing impaired or deaf, or that the licensee is a veteran. To be eligible for a veteran designation, the licensee must be an honorably discharged veteran of the armed forces of the United States. A licensee who requests a veteran designation shall submit Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs.

This rule is intended to implement Iowa Code sections 142C.3 and 321.189, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 1714C, IAB 11/12/14, effective 12/17/14]

**761—605.3(321) License class.** The driver's license class shall be coded on the face of the driver's license using these codes:

Class A—commercial driver's license

Class B—commercial driver's license

Class C—commercial driver's license

Class C—noncommercial driver's license

Class D—noncommercial driver's license, chauffeur

Class M—noncommercial driver's license, motorcycle only

This rule is intended to implement Iowa Code section 321.189.

**761—605.4(321) Endorsements.** The endorsements shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

**605.4(1) For a commercial driver's license.** The following endorsements may be added to a Class A, B or C commercial driver's license using these letter codes:

- H—Hazardous material
- P—Passenger
- N—Tank
- X—Hazardous material and tank
- T—Double/triple trailers
- S—School bus

**605.4(2) For a commercial learner's permit.** The following endorsements are the only endorsements that may be added to a commercial learner's permit using these letter codes. All other endorsements are prohibited on a commercial learner's permit.

- P—Passenger
- N—Tank
- S—School bus

**605.4(3) For a Class D driver's license (chauffeur).** The following endorsements may be added to a Class D driver's license using these number codes:

- 1—Truck-tractor semitrailer combination
- 2—Vehicle with 16,001 pounds gross vehicle weight rating or more. Not valid for truck-tractor semitrailer combination
- 3—Passenger vehicle less than 16-passenger design

**605.4(4) Motorcycle endorsement.** A motorcycle endorsement may be added to any driver's license that permits unaccompanied driving, other than a Class M driver's license or a motorized bicycle license, using the following letter code:

- L—Motorcycle

This rule is intended to implement Iowa Code sections 321.180 as amended by 2015 Iowa Acts, House File 635, section 50, and 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—605.5(321) Restrictions.** Restrictions shall be coded on the face of the driver's license and explained in text on the back of the driver's license. For purposes of this rule, "CMV" means commercial motor vehicle.

**605.5(1) For all licenses.** The following restrictions may apply to any driver's license:

- B—Corrective lenses required
- C—Mechanical aid (as detailed in the restriction on the back of the card)
- D—Prosthetic aid (as detailed in the restriction on the back of the card)
- F—Left and right outside rearview mirrors
- G—No driving when headlights required
- H—Temporary restricted license or permit (work permit)
- I—Ignition interlock required
- J—Restrictions on the back of card
- S—SR required (proof of financial responsibility for the future)
- T—Medical report required at renewal
- U—Not valid for 2-wheel vehicle
- W—Restricted commercial driver's license (CDL)
- Y—Intermediate license

**605.5(2) For a noncommercial driver's license.** The following restrictions apply only to a noncommercial driver's license:

- 8—Special instruction permit
- 9—Passenger restriction for intermediate license
- Q—No interstate or freeway driving

**605.5(3)** *For a commercial driver's license.* The following restrictions apply to a commercial driver's license:

- E—No manual transmission equipped CMV
- K—Intrastate only
- L—No air brake equipped CMV
- M—No Class A passenger vehicle
- N—No Class A and B passenger vehicle
- O—No tractor trailer CMV
- V—Medical variance
- Z—No full air brake equipped CMV

**605.5(4)** *For a commercial learner's permit.* The following restrictions apply to a commercial learner's permit.

- K—Intrastate only
- L—No air brake equipped CMV
- M—No Class A passenger vehicle
- N—No Class A and B passenger vehicle
- P—No passengers in CMV bus
- V—Medical variance
- X—No cargo in CMV tank vehicle

**605.5(5)** *Special licenses.* A numbered restriction will designate a special driver's license using these codes:

- 1—Motorcycle instruction permit
- 2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)
- 3—Commercial learner's permit
- 4—Chauffeur's instruction permit
- 5—Motorized bicycle license
- 6—Minor's restricted license
- 7—Minor's school license

**605.5(6)** *Additional information.*

*a. Reexamination or report.* The department may issue a restriction requiring a person to reappear at a specified time for examination. The department may require a medical report to be submitted. The department shall send Form 430029 as a reminder to appear.

*b. Loss of consciousness or voluntary control.*

(1) If a person is licensed pursuant to 761—subrule 600.4(4), the department shall issue the first driver's license with a restriction stating: "Medical report to be furnished at the end of six months."

(2) If this medical report shows that the person has been free of an episode of loss of consciousness or voluntary control since the previous medical report and the report recommends licensing, the department shall issue a duplicate driver's license with a restriction stating: "Medical report required at renewal." At each renewal accompanied by a favorable medical report, the department shall issue a two-year driver's license with the same restriction.

(3) If the latest medical report indicates the person experienced only a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating or has not treated the person for the episode and believes it is unlikely to recur, the department may waive the medical report requirement upon receipt of a favorable recommendation from a qualified medical professional.

(4) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control and has not been prescribed medications to control such episodes during the 24-month period immediately preceding application for a license.

(5) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file

with the department indicates the person has not had an episode of loss of consciousness or voluntary control during the 10-year period immediately preceding application for a license.

*c. Financial responsibility.* When a person is required under Iowa Code chapter 321A to have future proof of financial responsibility on file, the license restriction will read: “SR required.” The license shall be valid only for the operation of motor vehicles covered by the class of license issued and by the proof of financial responsibility filed.

*d. Vision restriction.* Restrictions relating to vision are addressed in 761—Chapter 604.

This rule is intended to implement Iowa Code chapter 321A and sections 321.178, 321.180 as amended by 2015 Iowa Acts, House File 635, section 50, 321.180A, 321.180B, 321.188 as amended by 2015 Iowa Acts, House File 635, section 53, 321.189, 321.193, 321.194, 321.215, 321J.4, and 321J.20. [ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0661C, IAB 4/3/13, effective 5/8/13; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—605.6(321) License term for temporary foreign national.** A driver’s license issued to a person who is a foreign national with temporary lawful status shall be issued only for the length of time the person is authorized to be present as verified by the department, not to exceed two years. However, if the person’s lawful status as verified by the department has no expiration date, the driver’s license shall be issued for a period of no longer than one year.

This rule is intended to implement Iowa Code section 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37. [ARC 0347C, IAB 10/3/12, effective 11/7/12]

**761—605.7(321L) Handicapped designation.** Rescinded IAB 2/11/98, effective 3/18/98.

**761—605.8** Reserved.

**761—605.9(321) Fees for driver’s licenses.** Fees for driver’s licenses are specified in Iowa Code section 321.191. A license fee may be paid by cash, check, credit card, debit card or money order. If payment is by check, the following requirements apply:

**605.9(1)** The check shall be for the exact amount of the fee and shall be payable to: Treasurer, State of Iowa. An exception may be made when a traveler’s check is presented.

**605.9(2)** One check may be used to pay fees for several persons, such as members of a family or employees of a business firm. One check may pay all fees involved, such as the license fee and the reinstatement fee.

This rule is intended to implement Iowa Code section 321.191. [ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—605.10(321) Waiver or refund of license fees.** Rescinded IAB 2/8/12, effective 3/14/12.

**761—605.11(321) Duplicate license.**

**605.11(1) Lost, stolen or destroyed license.** To replace a valid license that is lost, stolen or destroyed, the licensee shall comply with the requirements of 761—601.5(321) and pay the replacement fee.

**605.11(2) Voluntary replacement.** The department shall issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the replacement fee is paid. Voluntary replacement includes but is not limited to:

*a.* Replacement of a damaged license.

*b.* Replacement to change the current residential address on a license. The licensee shall comply with the requirements of 761—subrule 601.5(3) to establish a change of current residential address.

*c.* Replacement to change the name on a license. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.

*d.* Replacement to change the date of birth on a license. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.

*e.* Replacement to change the sex designation on a license. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.

- f.* Issuance of a license without the words “under 21” to a licensee who is 21 years of age or older.
- g.* Issuance of a license without the words “under 18” to a licensee who is 18 years of age or older. (If the licensee is under 21 years of age, the words “under 21” will replace the words “under 18.”)
- h.* Issuance of a noncommercial driver’s license to an eligible person who has been disqualified from operating a commercial motor vehicle.
- i.* Replacement of a valid license before its expiration date to obtain a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license). The licensee shall comply with the requirements of 761—601.5(321) to obtain a REAL ID license.
- j.* Replacement to add a veteran designation to the license. To be eligible for a veteran designation, the licensee must be an honorably discharged veteran of the armed forces of the United States. A licensee who requests a veteran designation shall submit Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs.

**605.11(3) Fee.** The fee to replace a license is \$10. Anything in this rule, notwithstanding the fee for replacement of a license under paragraphs 605.11(2) “*f*” and 605.11(2) “*g*,” shall be as set forth in Iowa Code subsection 321.189(6).

This rule is intended to implement Iowa Code sections 321.189, 321.195 and 321.208, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 1714C, IAB 11/12/14, effective 12/17/14]

#### **761—605.12(321) Address changes.**

**605.12(1)** A licensee shall notify the department of a change in the licensee’s mailing address within 30 days of the change. Notice shall be given by:

- a.* Submitting the address change in writing to the office of driver services, or
- b.* Appearing in person to change the mailing address at any driver’s license examination station.

**605.12(2)** Parents or legal guardians may provide written notice of a mailing address change on behalf of their minor children.

**605.12(3)** The department may use U.S. Postal Service address information to update its address records.

This rule is intended to implement Iowa Code sections 321.182 and 321.184.

#### **761—605.13 and 605.14 Reserved.**

#### **761—605.15(321) License extension.**

**605.15(1) Six-month extension.** An Iowa resident may apply for a six-month extension of a license if the resident:

- a.* Has a valid license,
- b.* Is eligible for further licensing, and
- c.* Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

**605.15(2) Procedure.** The licensee shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver’s license examination station. The licensee may also apply by letter to the address in 761—600.2(17A).

*a.* A six-month extension shall be added to the expiration date on the license. When the licensee appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

*b.* The department shall allow only two six-month extensions.

This rule is intended to implement Iowa Code section 321.196.

#### **761—605.16(321) Military extension.**

**605.16(1) Form 430028.** A person who qualifies for a military extension of a valid license should request Form 430028 from the department and carry it with the license for verification to peace officers. Form 430028 explains the provisions of Iowa Code section 321.198 regarding military extensions.

**605.16(2) Request for retention of record.** A person with a military extension may request that the department retain the record of license issuance for the duration of the extension or reenter the record if it has been removed from department records. The request may be made by letter or by using Form 430081. The letter or Form 430081 shall be signed by the person's commanding officer to verify the military service and shall be submitted to the department at the address in 761—600.2(17A).

**605.16(3) Renewal of license after military extension.** When an applicant renews a license after a military extension, the department may require the applicant to provide documentation of both the military service and the date of separation from military service.

**605.16(4) Reinstatement after sanction.** A person with a military extension whose license has been canceled, suspended or revoked shall comply with the requirements of 761—615.40(321) to reinstate the license.

This rule is intended to implement Iowa Code section 321.198.

**761—605.17 to 605.19** Reserved.

**761—605.20(321) Fee adjustment for upgrading license.** The fee for upgrading a driver's license shall be computed on a full-year basis. The fee is charged for each year or part of a year between the date of the change and the expiration date on the license.

**605.20(1)** The fee to upgrade a driver's license from one class to another is determined by computing the difference between the current license fee and the new license fee as follows:

- a. Converting noncommercial Class C to Class D—\$4 per year of new license validity.
- b. Converting Class M to Class D with a motorcycle endorsement—\$4 per year of new license validity.
- c. Converting Class M to noncommercial Class C with a motorcycle endorsement—\$2 one-time fee.

**605.20(2)** The fee to add a privilege to a driver's license is computed per year of new license validity as follows:

Noncommercial Class C (full privileges from a restricted Class C)	\$4 per year
Motorized bicycle	\$4 per year
Minor's restricted license	\$4 per year
Minor's school license	\$4 per year
Motorcycle instruction permit	\$2 per year
Motorcycle endorsement	\$2 per year

This rule is intended to implement Iowa Code sections 321.189 and 321.191.  
[ARC 1714C, IAB 11/12/14, effective 12/17/14]

**761—605.21 to 605.24** Reserved.

**761—605.25(321) License renewal.**

**605.25(1)** A licensee who wishes to renew a driver's license shall apply to the department and, if required, pass the appropriate examination.

**605.25(2)** A valid license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier.

**605.25(3)** A valid license may be renewed within 60 days after the expiration date, unless otherwise specified.

**605.25(4)** If the licensee's current residential address, name, date of birth, or sex designation has changed since the previous license was issued, the licensee shall comply with the following:

- a. *Current residential address.* The licensee shall comply with the requirements of 761—subrule 601.5(3) to establish a change of current residential address.

*b. Name.* The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.

*c. Date of birth.* The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.

*d. Sex designation.* The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.

**605.25(5)** A licensee who has not previously been issued a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license) and wishes to obtain a REAL ID license upon renewal must comply with the requirements of 761—601.5(321) to obtain a REAL ID license upon renewal.

**605.25(6)** A licensee who is a foreign national with temporary lawful status must provide documentation of lawful status as required by 761—subrule 601.5(4) at each renewal.

**605.25(7)** The department may determine means or methods for electronic renewal of a driver's license.

*a.* An applicant who meets the following criteria may apply for electronic renewal:

(1) The applicant must be at least 18 years of age but not yet 70 years of age.

(2) The applicant completed a satisfactory vision screen or submitted a satisfactory vision report under 761—subrules 604.10(1) to 604.10(3) and updated the applicant's photo at the applicant's last issuance or renewal.

(3) The applicant's driver's license has not been expired for more than one year.

(4) The department's records show the applicant is a U.S. citizen.

(5) The applicant's driver's license is not marked "valid without photo."

(6) The applicant is not seeking to change any of the following information as it appears on the applicant's driver's license:

1. Name.

2. Date of birth.

3. Sex.

(7) The applicant's driver's license is a Class C noncommercial driver's license, a Class D noncommercial driver's license (chauffeur), or Class M noncommercial driver's license (motorcycle) that is not a special license or permit, a temporary restricted license, or a two-year license.

(8) The applicant is not subject to a pending request for reexamination.

(9) The applicant does not wish to change any of the following:

1. Class of license.

2. License endorsements.

3. License restrictions.

(10) The applicant is not subject to any of the following restrictions:

G—No driving when headlights required

J—Restrictions on the back of card

T—Medical report required at renewal

8—Special instruction permit

Q—No interstate or freeway driving

R—Maximum speed of 35 mph

*b.* The department reserves the right to deny electronic renewal and to require the applicant to personally apply for renewal at a driver's license examination station if it appears to the department that the applicant may have a physical or mental condition that may impair the applicant's ability to safely operate a motor vehicle, even if the applicant otherwise meets the criteria in 605.25(7) "a."

c. An applicant who has not previously been issued a driver's license that is compliant with the REAL ID Act of 2005, 49 U.S.C. Section 30301 note, as further defined in 6 CFR Part 37 (a REAL ID license) may not request a REAL ID driver's license by electronic renewal.

This rule is intended to implement Iowa Code sections 321.186 and 321.196 as amended by 2013 Iowa Acts, House File 355, section 1, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—605.26(321) License renewal by mail.** Rescinded IAB 3/20/02, effective 4/24/02.

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<sup>1</sup> Effective date of December 29, 1993, for 761—605.26(2) "a" and "d," delayed 70 days by the Administrative Rules Review Committee at its meeting held December 15, 1993; delay lifted by this Committee on January 5, 1994, effective January 6, 1994.

CHAPTER 607  
COMMERCIAL DRIVER LICENSING

**761—607.1(321) Scope.** This chapter applies to licensing persons for the operation of commercial motor vehicles. Unless otherwise stated, the provisions of this chapter are in addition to other motor vehicle licensing rules.

This rule is intended to implement Iowa Code chapter 321.

**761—607.2(17A) Information.**

**607.2(1) Information and location.** Applications, forms and information about the commercial driver's license (CDL) are available at any driver's license examination station. Assistance is also available by mail from the Office of Driver Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (800)532-1121 or (515)244-8725; or by facsimile at (515)237-3071.

**607.2(2) Manual.** A copy of a study manual for the commercial driver's license tests is available upon request at any driver's license examination station.

This rule is intended to implement Iowa Code section 17A.3.

**761—607.3(321) Definitions.** The definitions in Iowa Code section 321.1 as amended by 2015 Iowa Acts, House File 635, section 44, apply to this chapter of rules. In addition, the following definitions are adopted:

*"Air brake system"* means a system that uses air as a medium for transmitting pressure or force from the driver's control to the service brake. "Air brake system" shall include any braking system operating fully or partially on the air brake principle.

*"Air over hydraulic brakes"* means any braking system operating partially on the air brake and partially on the hydraulic brake principle.

*"Automatic transmission"* means any transmission other than a manual transmission.

*"CDLIS"* means "commercial driver's license information system" as defined in Iowa Code section 321.1 as amended by 2015 Iowa Acts, House File 635, section 44.

*"Commercial driver's license downgrade"* or *"CDL downgrade"* means either:

1. The driver changes the driver's self-certification of type of driving from non-excepted interstate to excepted interstate, non-excepted intrastate, or excepted intrastate driving, or
2. The department removed the CDL privilege from the driver's license.

*"Commercial motor vehicle"* or *"CMV"* as defined in Iowa Code section 321.1 does not include a motor vehicle designed as off-road equipment rather than as a motor truck, such as a forklift, motor grader, scraper, tractor, trencher or similar industrial-type equipment. "Commercial motor vehicle" also does not include self-propelled implements of husbandry described in Iowa Code subsection 321.1(32).

*"Controlled substance"* as used in Iowa Code section 321.208 means a substance defined in Iowa Code section 124.101.

*"Hazardous materials"* means any material that has been designated as hazardous under 49 U.S.C. Section 5103 and is required to be placarded under 49 CFR Part 172, Subpart F, or any quantity of a material listed as a select agent or toxin in 42 CFR Part 73.

*"Manual transmission"* means a transmission utilizing a driver-operated clutch that is activated by a pedal or lever and a gear-shift mechanism operated either by hand or by foot. All other transmissions, whether semi-automatic or automatic, will be considered automatic.

*"Medical examiner"* means a person who is licensed, certified or registered, in accordance with applicable state laws and regulations, to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced registered nurse practitioners, and doctors of chiropractic.

*"Medical examiner's certificate"* means a certificate completed and signed by a medical examiner under the provisions of 49 CFR Section 391.43.

“*Medical variance*” means a driver has received one of the following from the Federal Motor Carrier Safety Administration that allows the driver to be issued a medical certificate:

1. An exemption letter permitting operation of a commercial motor vehicle pursuant to 49 CFR Part 381, Subpart C, or 49 CFR Section 391.62, or 49 CFR Section 391.64.
2. A skill performance evaluation certificate permitting operation of a commercial motor vehicle pursuant to 49 CFR Section 391.49.

“*Passenger vehicle*” means either of the following:

1. A motor vehicle designed to transport 16 or more persons including the operator.
2. A motor vehicle of a size and design to transport 16 or more persons including the operator which is redesigned or modified to transport fewer than 16 persons with disabilities. The size of a redesigned or modified vehicle shall be any such vehicle with a gross vehicle weight rating of 10,001 or more pounds.

“*School bus*” means a commercial motor vehicle used to transport pre-primary, primary, or secondary school students from home to school, from school to home, or to and from school-sponsored events. “School bus” does not include a bus used as a common carrier.

“*Self-certification*” means a written certification of which category of type of driving an applicant for a commercial driver’s license engages in or intends to engage in, from the following categories:

1. Non-excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, is both subject to and meets the qualification requirements under 49 CFR Part 391, and is required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
2. Excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR Section 390.3(f), 391.2, 391.68 or 398.3 from all or parts of the qualification requirements of 49 CFR Part 391, and is therefore not required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
3. Non-excepted intrastate. The person certifies that the person operates only in intrastate commerce and is subject to state driver qualification requirements.
4. Excepted intrastate. The person certifies that the person operates only in intrastate commerce, but engages exclusively in transportation or operations excepted from all or parts of the state driver qualification requirements as set forth in Iowa Code section 321.449.

“*State,*” as used in this chapter and in “another state” in Iowa Code subsection 321.174(2), “former state of residence” in Iowa Code subsection 321.188(5), or “any state” in Iowa Code subsection 321.208(1), means one of the United States or the District of Columbia unless the context means the state of Iowa.

This rule is intended to implement Iowa Code sections 321.1 as amended by 2015 Iowa Acts, House File 635, section 44, 321.174, 321.188 as amended by 2015 Iowa Acts, House File 635, section 53, 321.191, 321.193, 321.207 and 321.208.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.4 and 607.5** Reserved.

**761—607.6(321) Exemptions.**

**607.6(1) *Persons exempt.*** A person listed in Iowa Code section 321.176A is exempt from commercial driver licensing requirements.

**607.6(2) *Exempt until April 1, 1992.*** Rescinded IAB 6/23/93, effective 7/28/93.

This rule is intended to implement Iowa Code sections 321.1 and 321.176A.

**761—607.7(321) Records.** The operating record of a person who has been issued a commercial driver’s license or a commercial learner’s permit or a person who has been disqualified from operating

a commercial motor vehicle shall be maintained as provided in the department's "Record Management Manual" adopted in 761—Chapter 4.

This rule is intended to implement Iowa Code sections 22.11, 321.12 as amended by 2015 Iowa Acts, House File 635, section 46, and 321.199.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.8** and **607.9** Reserved.

**761—607.10(321) Adoption of federal regulations.**

**607.10(1) Code of Federal Regulations.** The department's administration of commercial driver's licenses shall be in compliance with the state procedures set forth in 49 CFR Section 383.73, and this chapter shall be construed to that effect. The department adopts the following portions of the Code of Federal Regulations which are referenced throughout this chapter of rules:

- a. 49 CFR Section 391.11 as adopted in 761—Chapter 520.
- b. 49 CFR Section 392.5 as adopted in 761—Chapter 520.
- c. The following portions of 49 CFR Part 383 (October 1, 2014):
  - (1) Section 383.51, Disqualification of drivers.
  - (2) Subpart E—Testing and Licensing Procedures.
  - (3) Subpart G—Required Knowledge and Skills.
  - (4) Subpart H—Tests.

**607.10(2) Copies of regulations.** Copies of the federal regulations may be reviewed at the state law library or through the Internet at <http://www.fmcsa.dot.gov>.

This rule is intended to implement Iowa Code sections 321.187, 321.188 as amended by 2015 Iowa Acts, House File 635, section 53, 321.207, 321.208 and 321.208A.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.11** to **607.14** Reserved.

**761—607.15(321) Application.** An applicant for a commercial driver's license shall comply with the requirements of Iowa Code sections 321.180(2)"e" as amended by 2015 Iowa Acts, House File 635, section 50, 321.182 and 321.188 as amended by 2015 Iowa Acts, House File 635, section 53, and 761—Chapter 601, and must provide the proofs of citizenship or lawful permanent residence and state of domicile required by 49 CFR Section 383.71. If the applicant is domiciled in a foreign jurisdiction and applying for a nondomiciled commercial driver's license, the applicant must provide a document required by 49 CFR Section 383.71(f).

This rule is intended to implement Iowa Code sections 321.180 as amended by 2015 Iowa Acts, House File 635, section 50, 321.182 and 321.188 as amended by 2015 Iowa Acts, House File 635, section 53.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.16(321) Commercial driver's license (CDL).**

**607.16(1) Classes.** The department may issue a commercial driver's license only as a Class A, B or C driver's license. The license class identifies the types of vehicles that may be operated. A commercial driver's license may have endorsements which authorize additional vehicle operations or restrictions which limit vehicle operations.

**607.16(2) Validity.**

a. A Class A commercial driver's license allows a person to operate a combination of commercial motor vehicles as specified in Iowa Code paragraph 321.189(1)"a." With the required endorsements and subject to the applicable restrictions, a Class A commercial driver's license is valid to operate any vehicle.

b. A Class B commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)"b." With the required endorsements and subject to the applicable restrictions, a Class B commercial driver's license is valid to operate any vehicle

except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A commercial driver's license.

*c.* A Class C commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)“c.” With the required endorsements and subject to the applicable restrictions, a Class C commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A or Class B commercial driver's license.

*d.* A commercial driver's license is valid for operating a motorcycle as a commercial motor vehicle only if the license has a motorcycle endorsement and a hazardous material endorsement. A commercial driver's license is valid for operating a motorcycle as a noncommercial motor vehicle only if the license has a motorcycle endorsement.

*e.* A commercial driver's license valid for eight years shall be issued to a qualified applicant who is at least 18 years of age but not yet 72 years of age. However, the expiration date of the license issued shall not exceed the licensee's 74th birthday.

*f.* A commercial driver's license valid for two years shall be issued to a qualified applicant 72 years of age or older. A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

*g.* A commercial driver's license is valid for 60 days after the expiration date.

*h.* A person with a commercial driver's license valid for the vehicle operated is not required to obtain a Class D driver's license to operate the vehicle as a chauffeur.

**607.16(3) Requirements.**

*a.* The minimum age to obtain a commercial driver's license is 18 years.

*b.* The applicant shall meet the requirements set forth in rule 761—607.15(321).

**607.16(4) Transition from five-year to eight-year licenses.** During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department's computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

This rule is intended to implement Iowa Code sections 321.177, 321.182, 321.188, 321.189, and 321.196 and 2013 Iowa Acts, chapter 104, section 2.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.17(321) Endorsements.** All endorsements except the hazardous material endorsement continue to be valid without retesting or additional fees when renewing or upgrading a license. The endorsements that authorize additional commercial motor vehicle operations with a commercial driver's license are:

**607.17(1) Hazardous material.** A hazardous material endorsement (H) is required to transport hazardous materials. Upon license renewal, retesting and fee payment are required. Retesting and fee payment are also required when an applicant upgrades an Iowa license or transfers a commercial driver's license from another state unless the applicant provides evidence of passing the endorsement test within the preceding 24 months. A farmer or a person working for a farmer is not subject to the hazardous material endorsement while operating either a pickup or a special truck within 150 air miles of the farmer's farm to transport supplies to or from the farm.

**607.17(2) Passenger vehicle.** A passenger vehicle endorsement (P) is required to operate a passenger vehicle as defined in rule 761—607.3(321).

**607.17(3) Tank vehicle.** A tank vehicle endorsement (N) is required to operate a tank vehicle as defined in Iowa Code section 321.1 as amended by 2015 Iowa Acts, House File 635, section 44. A vehicle transporting a tank, regardless of the tank's capacity, which does not otherwise meet the definition of a commercial motor vehicle in Iowa Code section 321.1 is not a tank vehicle.

**607.17(4) Double/triple trailer.** A double/triple trailer endorsement (T) is required to operate a commercial motor vehicle with two or more towed trailers when the combination of vehicles meets the criteria for a Class A commercial motor vehicle. Operation of a triple trailer combination vehicle is not permitted in Iowa.

**607.17(5) Hazardous material and tank.** A combined endorsement (X) authorizes both hazardous material and tank vehicle operations.

**607.17(6) School bus.** After September 30, 2005, a school bus endorsement (S) is required to operate a school bus as defined in rule 761—607.3(321). An applicant for a school bus endorsement must also qualify for a passenger vehicle endorsement.

**607.17(7) Exceptions for towing operations.**

*a.* A driver who tows a vehicle in an emergency “first move” from the site of a vehicle malfunction or accident on a highway to the nearest appropriate repair facility is not required to have the endorsement(s) applicable to the towed vehicle. In any subsequent move, a driver who tows a vehicle from one repair or disposal facility to another is required to have the endorsement(s) applicable to the towed vehicle with one exception: A tow truck driver is not required to have a passenger endorsement to tow a passenger vehicle.

*b.* The double/triple trailer endorsement is not required to operate a commercial motor vehicle with two or more towed vehicles that are not trailers.

This rule is intended to implement Iowa Code sections 321.1 as amended by 2015 Iowa Acts, House File 635, section 44, 321.176A, and 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.18(321) Restrictions.** The restrictions that may limit commercial motor vehicle operation with a commercial driver’s license are listed in 761—subrule 605.5(3) and are explained below:

**607.18(1) Air brake.** The air brake restriction (L, no air brake equipped CMV) applies to a licensee who either fails the air brake component of the knowledge test or performs the skills test in a vehicle not equipped with air brakes and prohibits the operation of a commercial motor vehicle equipped with an air brake system until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(2) Full air brake.** The full air brake restriction (Z, no full air brake equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with air over hydraulic brakes and prohibits the operation of a commercial motor vehicle equipped with any braking system operating fully on the air brake principle until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(3) Manual transmission.** The manual transmission restriction (E, no manual transmission equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with automatic transmission and prohibits the operation of a commercial motor vehicle equipped with a manual transmission until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(4) Tractor-trailer.** The tractor-trailer restriction (O, no tractor trailer CMV) applies to a licensee who performs the skills test in a combination vehicle for a Class A commercial driver’s license with the power unit and towed unit connected with a pintle hook or other non-fifth wheel connection and prohibits operation of a tractor-trailer combination connected by a fifth wheel that requires a Class A commercial driver’s license until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(5) Class A passenger vehicle.** The Class A passenger vehicle restriction (M, no Class A passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class B commercial driver’s license and prohibits operation of a passenger vehicle that requires a Class A commercial driver’s license.

**607.18(6) Class A and B passenger vehicle.** The Class A and B passenger vehicle restriction (N, no Class A and B passenger vehicle) applies to a licensee who applies for a passenger endorsement and

performs the skills test in a passenger vehicle that requires a Class C commercial driver's license and prohibits operation of a passenger vehicle that requires a Class A or Class B commercial driver's license.

**607.18(7) *Intrastate only.*** The intrastate only restriction (K, intrastate only) applies to a licensee who self-certifies to non-excepted intrastate or excepted intrastate driving and prohibits the operation of a commercial motor vehicle in interstate commerce.

**607.18(8) *Medical variance.*** The medical variance restriction (V, medical variance) applies to a licensee when the department is notified pursuant to 49 CFR Section 383.73(o)(3) that the driver has been issued a medical variance and indicates there is information about a medical variance on the CDLIS driver record.

This rule is intended to implement Iowa Code sections 321.189 and 321.191 as amended by 2015 Iowa Acts, House File 635, section 55.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.19** Reserved.

**761—607.20(321) Commercial learner's permit.**

**607.20(1) *Validity.***

*a.* A commercial learner's permit allows the permit holder to operate a commercial motor vehicle when accompanied as required by Iowa Code section 321.180(2) "d" as amended by 2015 Iowa Acts, House File 635, section 50.

*b.* A commercial learner's permit is valid for 180 days and may be renewed for an additional 180 days without retaking the general and endorsement knowledge tests required by Iowa Code section 321.188 as amended by 2015 Iowa Acts, House File 635, section 53.

*c.* A commercial learner's permit is invalid after the expiration date of the underlying commercial or noncommercial driver's license issued to the permit holder or the expiration date of the permit whichever occurs first.

*d.* The issuance of a commercial learner's permit is a precondition to the initial issuance of a commercial driver's license. The issuance of a commercial learner's permit is also a precondition to the upgrade of a commercial driver's license if the upgrade requires a skills test. The holder of a commercial learner's permit is not eligible to take a required driving skills test for the first 14 days after the permit holder is issued the permit. The 14-day period includes the day the commercial learner's permit was issued.

EXAMPLE: The commercial learner's permit is issued on September 1. The earliest date the permit holder would be eligible to take the skills test is September 15.

*e.* A commercial learner's permit is not valid for the operation of a vehicle transporting hazardous materials.

**607.20(2) *Requirements.***

*a.* An applicant for a commercial learner's permit must hold a valid Class A, B, C, or D driver's license issued in this state other than an instruction permit, a special instruction permit, a motorized bicycle license or a temporary restricted license, must be at least 18 years of age, and must meet the requirements to obtain a valid commercial driver's license, including the requirements set forth in Iowa Code section 321.188 as amended by 2015 Iowa Acts, House File 635, section 53. However, the applicant does not have to complete the driving skills tests required for a commercial driver's license to obtain a commercial learner's permit.

*b.* The applicant must successfully pass a general knowledge test that meets the federal standards contained in 49 CFR Part 383, Subparts F, G and H, for the commercial motor vehicle the applicant operates or expects to operate, including any endorsement for which the applicant applies.

**607.20(3) *Endorsements.*** A commercial learner's permit may include the following endorsements. All other endorsements are prohibited on a commercial learner's permit.

*a.* An applicant for a passenger endorsement (P) must take and pass the passenger endorsement knowledge test. A commercial learner's permit holder with a passenger endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and

inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d" as amended by 2015 Iowa Acts, House File 635, section 50.

*b.* An applicant for a school bus endorsement (S) must take and pass the school bus endorsement knowledge test. A commercial learner's permit holder with a school bus endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d" as amended by 2015 Iowa Acts, House File 635, section 50.

*c.* An applicant for a tank vehicle endorsement (N) must take and pass the tank vehicle endorsement knowledge test. A commercial learner's permit holder with a tank vehicle endorsement may only operate an empty tank vehicle and is prohibited from operating any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

**607.20(4) Restrictions.** A commercial learner's permit may include the air brake (L), medical variance (V), Class A passenger vehicle (M), Class A and B passenger vehicle (N) and intrastate only (K) restrictions described in rule 761—607.18(321). In addition, a commercial learner's permit may include the following restrictions that are specific to the commercial learner's permit:

*a. Passenger.* The passenger restriction (P, no passengers in CMV bus) applies to a permit holder who has a commercial learner's permit with a passenger or school bus endorsement and prohibits the operation of a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d" as amended by 2015 Iowa Acts, House File 635, section 50.

*b. Cargo.* The cargo restriction (X, no cargo in CMV tank vehicle) applies to a permit holder who has a commercial learner's permit with a tank vehicle endorsement and prohibits the operation of any tank vehicle containing cargo or any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

This rule is intended to implement Iowa Code sections 321.180 as amended by 2015 Iowa Acts, House File 635, section 50, 321.186, and 321.188 as amended by 2015 Iowa Acts, House File 635, section 53.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.21 to 607.24** Reserved.

**761—607.25(321) Examination for a commercial driver's license.** In addition to the requirements of 761—Chapter 604, an applicant for a commercial driver's license shall pass the knowledge and skills tests as required in 49 CFR Part 383, Subparts G and H.

This rule is intended to implement Iowa Code section 321.186.

**761—607.26(321) Vision screening.** An applicant for a commercial driver's license or commercial learner's permit must pass a vision screening test administered by the department. The vision standards are given in 761—604.11(321).

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.27(321) Knowledge tests.**

**607.27(1) General knowledge test.** The general knowledge test for a commercial driver's license is a written test of topics such as vehicle inspection, operation, safety and control in accordance with 49 CFR Section 383.111.

**607.27(2) Additional tests.** In addition to the general knowledge test for a commercial driver's license, an additional knowledge test is required for each of the following:

*a.* Class A license for combination vehicle operation as required in 49 CFR Section 383.111.

- b. Hazardous material endorsement as required in 49 CFR Section 383.121. The knowledge test for a hazardous material endorsement shall not be administered orally or in a language other than English.
- c. Passenger vehicle endorsement as required in 49 CFR Section 383.117.
- d. Tank vehicle endorsement as required in 49 CFR Section 383.119.
- e. Double/triple trailer endorsement as required in 49 CFR Section 383.115.
- f. School bus endorsement as required in 49 CFR Section 383.123. The applicant must also qualify for a passenger vehicle endorsement.
- g. Removal of the air brake restriction as required in 49 CFR Section 383.111.

**607.27(3) Test methods.** All knowledge tests shall be administered in compliance with 49 CFR Section 383.133(b). All tests other than the hazardous material endorsement test may be administered in written form, verbally, or in automated format and can be administered in a foreign language, provided no interpreter is used in administering the test. A verbal test shall be offered only at specified locations. Information about the locations is available at any driver's license examination station.

**607.27(4) Waiver.** A waiver of any knowledge test is permitted only as provided in Iowa Code subsection 321.188(5). The burden of proof of having passed the hazardous material endorsement test within the preceding 24 months rests with the applicant.

**607.27(5) Requirement.** An applicant must pass the applicable knowledge test(s) before taking the skills test. Passing scores for a knowledge test shall meet the standards contained in 49 CFR Section 383.135(a).

This rule is intended to implement Iowa Code sections 321.186 and 321.188 as amended by 2015 Iowa Acts, House File 635, section 53.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

#### **761—607.28(321) Skills test.**

**607.28(1) Content.** The skills test for a commercial driver's license is a three-part test as required in 49 CFR Part 383, Subparts E, G and H.

**607.28(2) Test methods.** All skills tests shall be administered in compliance with 49 CFR Section 383.133(c). Interpreters are prohibited during the administration of skills tests. Applicants must be able to understand and respond to verbal commands and instructions in English by a skills test examiner. Neither the applicant nor the examiner may communicate in a language other than English during the skills test.

**607.28(3) Order.** The skills test must be administered and successfully completed in the following order: pre-trip inspection, basic vehicle control skills, on-road skills. If an applicant fails one segment of the skills test, the applicant cannot continue to the next segment of the test, and scores for the passed segments of the test are only valid during initial issuance of the commercial learner's permit. If the commercial learner's permit is renewed, all three segments of the skills test must be retaken. However:

- a. If the applicant wants to remove an air brake restriction, full air brake restriction, or manual transmission restriction, the applicant does not have to retake the complete skills test, and may complete a modified skills test that demonstrates the applicant can safely and effectively operate the vehicle's full air brakes, air over hydraulic brakes, or manual transmission. In addition, to remove the air brake or full air brake restriction, the applicant must successfully perform the air brake pre-trip inspection and pass the air brake knowledge test.

- b. If the applicant wants to remove the tractor-trailer restriction, the applicant must retake all three skills tests in a representative tractor-trailer.

**607.28(4) Vehicle.** The applicant shall provide a representative vehicle for the skills test. "Representative vehicle" means a commercial motor vehicle that meets the statutory description for the class of license applied for.

- a. To obtain a passenger vehicle endorsement applicable to a specific vehicle class, the applicant must take the skills test in a passenger vehicle, as defined in rule 761—607.3(321), satisfying the requirements of that class, as required in 49 CFR Section 383.117.

- b. To obtain a school bus endorsement, the applicant must qualify for a passenger vehicle endorsement and take the skills test in a school bus, as defined in rule 761—607.3(321), in the same

vehicle class as the applicant will drive, as required in 49 CFR Section 383.123. Up to and including September 30, 2005, the skills test for a school bus endorsement is waived for an applicant meeting the requirements of 49 CFR Section 383.123(b).

c. To remove an air brake or full air brake restriction, the applicant must take the skills test in a vehicle equipped with an air brake system, as defined in rule 761—607.3(321) and as required in 49 CFR Section 383.113.

d. To remove a manual transmission restriction, the applicant must take the skills test in a vehicle equipped with a manual transmission, as defined in rule 761—607.3(321).

**607.28(5) Skills test scoring.** Passing scores for a skills test shall meet the standards contained in 49 CFR Section 383.135(b).

**607.28(6) Military waiver.** The department may waive the requirement that an applicant pass a required skills test for an applicant who is on active duty in the military service or who has separated from such service in the past year, provided the applicant meets the requirements of Iowa Code subsection 321.188(6) as amended by 2015 Iowa Acts, House File 635, section 53.

**607.28(7) Locations.** The skills test for a commercial driver's license shall be given only at specified locations where adequate testing facilities are available. An applicant may contact any driver's license examination station for the location of the nearest skills testing station. A skills test by appointment shall be offered only at specified regional test sites.

This rule is intended to implement Iowa Code section 321.186 and section 321.188 as amended by 2015 Iowa Acts, House File 635, section 53.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.29(321) Waiver of skills test.** Rescinded IAB 6/23/93, effective 7/28/93.

**761—607.30** Reserved.

**761—607.31(321) Test results.**

**607.31(1) Period of validity.** Passing knowledge and skills test results shall remain valid for a period of 180 days.

**607.31(2) Retesting.** Subject to rule 761—607.28(321), an applicant shall be required to repeat only the knowledge test(s) or part(s) of the skills test that the applicant failed. An applicant who fails a test shall not be permitted to repeat that test the same day.

**607.31(3) Skills test results from other states.** As required by 49 CFR Section 383.79, the department shall accept the valid results of a skills test administered to an applicant who is domiciled in the state of Iowa and that was administered by another state, in accordance with 49 CFR Part 383, Subparts F, G and H, in fulfillment of the applicant's testing requirements under 49 CFR Section 383.71 and the state's test administration requirements under 49 CFR Section 383.73. The results must be transmitted directly from the testing state to the department as required by 49 CFR Section 383.79.

This rule is intended to implement Iowa Code section 321.186 and section 321.188 as amended by 2015 Iowa Acts, House File 635, section 53.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.32 to 607.34** Reserved.

**761—607.35(321) Issuance of commercial driver's license and commercial learner's permit.** A commercial driver's license or commercial learner's permit issued by the department shall include the information and markings required by Iowa Code section 321.189(2) "b" as amended by 2015 Iowa Acts, House File 635, section 54.

This rule is intended to implement Iowa Code section 321.189 as amended by 2015 Iowa Acts, House File 635, section 54.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.36(321) Conversion to commercial driver's license.** Rescinded IAB 6/23/93, effective 7/28/93.

**761—607.37(321) Commercial driver's license renewal.** The department shall administer commercial driver's license renewals as required by 49 CFR Section 383.73.

**607.37(1) Licensee requirements.** To renew a commercial driver's license, the licensee shall apply at a driver's license examination station and complete the following:

*a.* Make a written self-certification of type of driving as required by rule 761—607.50(321) and provide a current medical examiner's certificate if required.

*b.* If the licensee has and wishes to retain a hazardous material endorsement, the licensee shall pass the test required in 49 CFR Section 383.121 and comply with the Transportation Security Administration security threat assessment standards specified in 49 CFR Sections 383.71(b)(8) and 383.141 for such endorsement. A lawful permanent resident of the United States must also provide the licensee's U.S. Citizenship and Immigration Services alien registration number.

*c.* Provide proof of citizenship or lawful permanent residency and state of domicile as required by rule 761—607.15(321) and 49 CFR 383.71(d)(7). Proof of citizenship or lawful permanent residency is not required if the licensee provided such proof at initial issuance or a previous renewal or upgrade of the license and the department has a notation on the licensee's record confirming that the required proof of legal citizenship or legal presence check was made and the date on which it was made.

*d.* If the applicant is domiciled in a foreign jurisdiction and renewing a non-domiciled commercial driver's license, the applicant must provide a document required by 49 CFR 383.71(f) at each renewal.

**607.37(2) Early renewal.** A valid commercial driver's license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier, not to exceed one year prior to the expiration date. The department may allow renewal earlier than one year prior to the expiration date for active military personnel being deployed due to actual or potential military conflict.

This rule is intended to implement Iowa Code sections 321.186, 321.188 as amended by 2015 Iowa Acts, House File 635, section 53, and 321.196.

[ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.38(321) Transfers from another state.** Upon initial application for an Iowa license, an Iowa resident who has a valid commercial driver's license from a former state of residence is not required to retest except as specified in Iowa Code subsection 321.188(5) but is required to pay the applicable endorsement and restriction removal fees.

This rule is intended to implement Iowa Code sections 321.188 and 321.191.

**761—607.39(321) Disqualification.**

**607.39(1) Date.** A disqualifying act, action or offense under Iowa Code section 321.208, that occurred before July 1, 1990, shall not be grounds for disqualification from operating a commercial motor vehicle.

**607.39(2) Notice.** A 30-day advance notice of disqualification shall be served by the department in accordance with rule 761—615.37(321). Pursuant to Iowa Code subsection 321.208(9), a peace officer on behalf of the department may serve the notice of disqualification immediately.

**607.39(3) Hearing and appeal process.** A person who has received a notice of disqualification may contest the disqualification in accordance with 761—615.38(17A,321).

**607.39(4) Reduction of lifetime disqualification.** Reserved.

This rule is intended to implement Iowa Code chapter 17A and section 321.208.

**761—607.40(321) Sanctions.** When a person's motor vehicle license is denied, canceled, suspended, revoked or barred, the person is also disqualified from operating a commercial motor vehicle.

This rule is intended to implement Iowa Code section 321.208.

**761—607.41 to 607.44** Reserved.

**761—607.45(321) Reinstatement.** To reinstate a commercial driver's license after completion of a period of disqualification, a person shall appear at a driver's license examination station. The person

must also meet the vision standards for licensing, pass the applicable knowledge test(s) and the skills test, and pay the required reinstatement fee and the fees for a new license.

This rule is intended to implement Iowa Code sections 321.191 and 321.208.

**761—607.46 to 607.48** Reserved.

**761—607.49(321) Restricted commercial driver's license.**

**607.49(1) Scope.** This rule pertains to the issuance of restricted commercial driver's licenses to suppliers or employees of suppliers of agricultural inputs. Issuance is permitted by 49 CFR 383.3(f). A restricted commercial driver's license shall meet all requirements of a regular commercial driver's license, as set out in Iowa Code chapter 321 and this chapter of rules, except as specified in this rule.

**607.49(2) Agricultural inputs.** The term "agricultural inputs" means suppliers or applicators of agricultural chemicals, fertilizer, seed or animal feeds.

**607.49(3) Validity.**

*a.* A restricted commercial driver's license allows the licensee to drive a commercial motor vehicle for agricultural input purposes. The license is valid to:

- (1) Operate Group B and Group C commercial motor vehicles including tank vehicles and vehicles equipped with air brakes, except passenger vehicles.
- (2) Transport the hazardous materials listed in paragraph 607.49(3) "b."
- (3) Operate only during the current, validated seasonal period.
- (4) Operate between the employer's place of business and the farm currently being served, not to exceed 150 miles.

*b.* A restricted commercial driver's license is not valid for transporting hazardous materials requiring placarding, except as follows:

- (1) Liquid fertilizers such as anhydrous ammonia may be transported in vehicles or implements of husbandry with total capacities of 3,000 gallons or less.
- (2) Solid fertilizers such as ammonium nitrate may be transported provided they are not mixed with any organic substance.
- (3) A hazardous material endorsement is not needed to transport the products listed in the preceding subparagraphs.

*c.* When not driving for agricultural input purposes, the license is valid for operating a noncommercial motor vehicle that may be legally operated under the noncommercial license held by the licensee.

**607.49(4) Requirements.**

*a.* The applicant must have two years of previous driving experience. This means that the applicant must have held a license that permits unaccompanied driving for at least two years. This does not include a motorized bicycle license, a minor's school license or a minor's restricted license.

*b.* The applicant must have a good driving record for the most recent two-year period, as defined in subrule 607.49(5).

*c.* An applicant who currently holds a commercial driver's license or a commercial learner's permit is not eligible for issuance of a restricted commercial driver's license.

**607.49(5) Good driving record.** A "good driving record" means a driving record showing:

- a.* No multiple licenses.
- b.* No driver's license suspensions, revocations, disqualifications, denials, bars, or cancellations of any kind.
- c.* No convictions in any type of motor vehicle for:
  - (1) Driving under the influence of alcohol or drugs.
  - (2) Leaving the scene of an accident.
  - (3) Committing any felony involving a motor vehicle.
  - (4) Speeding 15 miles per hour or more over the posted speed limit.
  - (5) Reckless driving.
  - (6) Improper or erratic lane changes.

- (7) Following too closely.
- (8) Accident-connected traffic law violations.
- d. No record of at-fault accidents.

**607.49(6) Issuance.**

a. The knowledge and skills tests described in rules 761—607.27(321) and 761—607.28(321) are waived.

b. A restricted commercial driver's license shall be coded with restriction "W" on the face of the driver's license, with the restriction explained in text on the back of the driver's license. In addition, the license shall be issued with a restriction stating the license's validity.

c. The expiration date for a restricted commercial driver's license that is converted to this license from another Iowa license shall carry the same expiration date as the previous license.

d. A restricted commercial driver's license may be renewed for the period of time specified in Iowa Code section 321.196. The licensee's good driving record shall be confirmed at the time of renewal.

e. The fee for a restricted commercial driver's license shall be as specified in Iowa Code section 321.191.

f. There are two periods of validity for commercial motor vehicle operation: March 15 through June 30, and October 4 through December 14. These are referred to as "seasonal periods." Validity shall not exceed 180 days in any 12-month period. Any period of validity authorized previously by another state's license shall be considered a part of the 180-day maximum period of validity.

g. A restricted commercial driver's license must be validated for commercial motor vehicle operation for each seasonal period. This means that the applicant/licensee must appear at a driver's license examination station during the current seasonal period or not more than 30 days before the beginning of the period to have the person's good driving record confirmed. Upon confirmation, the department shall issue a replacement license with a restriction validating the license for that seasonal period, provided the person is otherwise eligible for the license. The fee for a replacement license shall be as specified in Iowa Code section 321.195.

h. The same process must be repeated for each seasonal period.

This rule is intended to implement Iowa Code section 321.176B.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.50(321) Self-certification of type of driving and submission of medical examiner's certificate.**

**607.50(1)** *Applicants for commercial learner's permit or new, transferred, renewed or upgraded CDL.*

a. A person shall provide to the department a self-certification of type of driving if the person is applying for:

- (1) A commercial learner's permit,
- (2) An initial commercial driver's license,
- (3) A transfer of a commercial driver's license from a prior state of domicile to the state of Iowa,
- (4) Renewal of a commercial driver's license, or
- (5) A license upgrade for a commercial driver's license or an endorsement authorizing the operation of a commercial motor vehicle not covered by the current commercial driver's license.

b. The self-certification shall be on a form or in a format, which may be electronic, as provided by the department.

**607.50(2)** *Enrollment of existing CDL holders.* Every person who holds a commercial driver's license on or after January 30, 2012, and up to January 30, 2014, and who has not otherwise made a self-certification of type of driving under subrule 607.50(1) shall make to the department a self-certification of type of driving. The self-certification may be made on or after January 30, 2012, but must be made no later than January 29, 2014.

**607.50(3)** *Submission of medical examiner's certificate by persons certifying to non-excepted interstate driving.* Every person who self-certifies to non-excepted interstate driving must give the department a copy of the person's current medical examiner's certificate. A person who fails to provide

a required medical examiner's certificate shall not be allowed to proceed with an initial issuance, transfer, renewal, or upgrade of a license until the person gives the department a medical examiner's certificate that complies with the requirements of this subrule, or changes the person's self-certification of type of driving to a type other than non-excepted interstate driving. For persons submitting a current medical examiner's certificate, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record. A person who self-certifies to a type of driving other than non-excepted interstate shall have no medical certification status on the CDLIS driver's record.

**607.50(4)** *Maintaining certified status.* To maintain a medical certification status of "certified," a person who self-certifies to non-excepted interstate driving must give the department a copy of each subsequently issued medical examiner's certificate valid for the person. The copy must be given to the department at least ten days before the previous medical examiner's certificate expires.

**607.50(5)** *CDL downgrade.* If the medical examiner's certificate or medical variance for a person self-certifying to non-excepted interstate driving expires or if the Federal Motor Carrier Safety Administration notifies the department that the person's medical variance was removed or rescinded, the department shall post a medical certification status of "not certified" to the person's CDLIS driver's record and shall initiate a downgrade of the person's commercial driver's license or commercial learner's permit. The medical examiner's certificate of a person who fails to maintain a medical certification status of "certified" as required by subrule 607.50(4) shall be deemed to be expired on the date of expiration of the last medical examiner's certificate filed for the person as shown by the person's CDLIS driver's record. The downgrade will be initiated and completed as follows:

*a.* The department shall give the person written notice that the person's medical certification status is "not certified" and that the commercial motor vehicle privileges will be removed from the person's commercial driver's license or commercial learner's permit 60 days after the date the medical examiner's certificate or medical variance expired or the medical variance was removed or rescinded unless the person submits to the department a current medical certificate or medical variance or self-certifies to a type of driving other than non-excepted interstate.

*b.* If the person submits a current medical examiner's certificate or medical variance before the end of the 60-day period, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record and shall terminate the downgrade of the person's commercial driver's license or commercial learner's permit.

*c.* If the person self-certifies to a type of driving other than non-excepted interstate before the end of the 60-day period, the department shall not remove the commercial motor vehicle privileges from the person's commercial driver's license or commercial learner's permit, and the person will have no medical certification status on the person's CDLIS driver's record.

*d.* If the person fails to take the action in either paragraph 607.50(5) "b" or "c" before the end of the 60-day period, the department shall remove the commercial motor vehicle privileges from the person's commercial driver's license or commercial learner's permit and shall leave the person's medical certification status as "not certified" on the person's CDLIS driver's record.

**607.50(6)** *CDL downgrade of existing CDL holders who fail to enroll before January 30, 2014.* Every person subject to subrule 607.50(2) who fails to make a self-certification of type of driving or fails to give the department a copy of the person's medical examiner's certificate as required by subrule 607.50(3) before January 30, 2014, shall be subject to a CDL downgrade. The department shall post a medical certification status of "not certified" to the CDLIS driver's record and shall initiate a downgrade of the driver's commercial driver's license following the procedure set forth in subrule 607.50(5). In such cases, the 60-day period shall begin January 30, 2014, and the person shall be required to make an initial self-certification of type of driving to terminate the CDL downgrade and to avoid removal of the commercial driver's license privilege. The person's status and privilege under subrule 607.50(5) shall be determined according to the certification made or not made.

**607.50(7)** *Establishment or reestablishment of "certified" status.* A person who has no medical certification status or whose medical certification status has been posted as "not certified" on the person's CDLIS driver's record may establish or reestablish the status as "certified" by submitting a current medical examiner's certificate or medical variance to the department. A person who has failed

to self-certify to a type of driving or has self-certified to a type of driving other than non-excepted interstate must also make a self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record.

**607.50(8) Reestablishment of the CDL privilege.** A person whose commercial motor vehicle privileges have been removed from the person’s commercial driver’s license or commercial learner’s permit under the provisions of paragraph 607.50(5) “d” may reestablish the commercial motor vehicle privileges by either of the following methods:

*a.* Submitting a current medical examiner’s certificate or medical variance to the department. A person who has failed to self-certify to a type of driving must also make an initial self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record and reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit.

*b.* Self-certifying to a type of driving other than non-excepted interstate. The department shall then reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit; the person will have no medical certification status on the driver’s CDLIS driver’s record.

**607.50(9) Change of type of driving.** A person may change the person’s self-certification of type of driving at any time. As required by subrule 607.50(3), a person certifying to non-excepted interstate driving must give the department a copy of the person’s current medical examiner’s certificate prepared by a medical examiner.

**607.50(10) Record keeping.** The department shall comply with the medical record-keeping requirements set forth in 49 CFR Section 383.73.

This rule is intended to implement Iowa Code sections 321.182, 321.188 as amended by 2015 Iowa Acts, House File 635, section 53, and 321.207 as amended by 2015 Iowa Acts, House File 635, section 60.

[ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

#### **761—607.51(321) Determination of gross vehicle weight rating.**

**607.51(1) Actual weight prohibited.** In determining whether the vehicle is a representative vehicle for the skills test and the group of commercial driver’s license for which the applicant is applying, the vehicle’s gross weight rating or gross combination weight rating must be used, not the vehicle’s actual gross weight or gross combination weight. For purposes of this rule, “gross weight rating” and “gross combination weight rating” mean as defined in 49 CFR Section 383.5.

**607.51(2) Vehicle without legible manufacturer’s certification label.** To complete a skills test using a vehicle that has no legible manufacturer’s certification label, whether a power unit or towed vehicle, the applicant must provide documentation of the vehicle’s gross vehicle weight rating, such as a manufacturer’s certificate of origin, a title, or the vehicle identification number information for the vehicle. In the absence of such documentation, the vehicle may not be used, either alone or in combination.

This rule is intended to implement Iowa Code section 321.1 as amended by 2015 Iowa Acts, House File 635, section 44.

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CHAPTER 71  
ADMINISTRATION OF THE CONVEYANCE SAFETY PROGRAM

**875—71.1(89A) Definitions.** The definitions contained in this rule shall apply to 875—Chapters 71, 72, and 73.

“*Acceptance checklist*” means a checklist available on the Web site of the division of labor services that includes a list of major systems and components of conveyances.

“*AECO*” means an elevator/escalator certification organization accredited pursuant to ASME A17.7.

“*Approved*” means approved by the division.

“*CCD*” means code compliance documentation as described in ASME A17.7, Section 2.10.

“*CEI*” means a person who is a certified elevator inspector or certified elevator inspector supervisor and who received the certification from a certifying organization that holds a valid document of accreditation issued by an accreditation body in accordance with ANSI/ISO/IEC 17024.

“*Control*” means the system governing the starting, stopping, direction of motion, acceleration, speed and deceleration of the moving member.

“*Conveyance*” means any elevator, escalator, dumbwaiter, wind tower lift, CPH, or other equipment governed by Iowa Code chapter 89A.

“*CPH*” means a construction personnel hoist.

“*CPH jump*” means the addition or removal of mast or tower allowing a change in the hoist service elevation of a CPH.

“*Division*” means the labor services division of the workforce development department.

“*Elevator*” means a hoisting and lowering mechanism equipped with a car or platform which moves in guides in a substantially vertical direction and which serves two or more floors of a building or structure. “Elevator” does not include a CPH.

“*Elevator mechanic*” means a person who meets the standard for “elevator personnel” found in ASME A17.1.

“*Hoistway-unit system*” means a series of hoistway-door interlocks, hoistway-door electric contacts or hoistway-door combination mechanical locks and electric contacts, or a combination thereof, the function of which is to prevent operation of the driving machine by the normal operating device unless all hoistway doors are in the closed position and, if required, locked.

“*Wind tower lift*” means a conveyance designed and utilized solely for movement of trained and authorized people and small loads in wind towers built for the production of electricity.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 1159C, IAB 10/30/13, effective 12/4/13]

**875—71.2(89A) Registration of conveyances.** The owner or authorized agent of each operable conveyance not previously registered shall register the conveyance. An application to install a new conveyance shall constitute registration. All registrations shall be submitted to the commissioner on forms available from the division of labor services and shall include all information requested by the labor commissioner.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.3(89A) State identification number.** The commissioner shall assign an identification number to each conveyance that shall be stamped on a metal tag permanently attached to the controller, to the electrical disconnecting switch, or in a wind tower lift cage.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.4(89A) Responsibility for obtaining permits.** The procuring of all permits and the payment of all fees required by this chapter shall be the responsibility of the owner. Failure to obtain the appropriate permit prior to installation, alteration or operation may, at the discretion of the labor commissioner, result in a referral to the attorney general for prosecution of criminal penalties as described in Iowa Code section 89A.17.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.5(89A) Installation permits.**

**71.5(1)** Installation shall not begin until an installation permit has been issued by the division. A separate installation permit shall be issued for each conveyance, except that a single installation permit shall cover all identical wind tower lifts installed as the result of one construction contract in identical wind towers in a single wind farm.

**71.5(2)** Application for an installation permit shall be accompanied by the fee specified in rule 875—71.16(89A), shall be in the format required by the labor commissioner, and shall include the following, as applicable:

- a.* Sectional plan of car and hoistway.
- b.* Sectional plan of machine room.
- c.* Sectional elevation of hoistway and machine room including the pit, bottom and top clearance of car and counterweights.
- d.* Size and weight of rails and guide rail bracket spacing.
- e.* The estimated maximum vertical forces on the guide rails on application of the safety device.
- f.* In the case of freight elevators for class B or class C loading, the horizontal forces on the guide rail faces during loading and unloading and the estimated maximum horizontal forces in a post-wise direction on the guide rail faces on the application of the safety device.
- g.* The size and weight per foot of any rail reinforcements where rail reinforcements are provided.
- h.* Job specifications.
- i.* For a conveyance covered by ASME A17.7, a complete copy of the CCD with attachments and a complete copy of the Certificate of Conformance with attachments as described by ASME A17.7, Appendix I, Section 4.5.
- j.* For a CPH, the number of CPH jumps planned, the planned dates for each CPH jump, and the change in the number of floors anticipated with each CPH jump.

**71.5(3)** A CPH installation permit issued in response to an application submitted in full compliance with this subrule permits each planned CPH jump. Each CPH jump shall be considered an alteration. The fee submitted for a CPH installation permit shall be the total of the CPH installation permit fee as set forth in subrule 71.16(3) and the CPH alteration permit fee as set forth in subrule 71.16(4).

**71.5(4)** Issuance of an installation permit shall not be construed as a waiver or variance of any requirement of law.

**71.5(5)** The installation permit or a copy of the installation permit shall be conspicuously posted at the worksite. All the wind towers covered by a single installation permit shall be considered a single worksite, and posting one copy of the installation permit at the construction project office shall be sufficient compliance with this subrule.

**71.5(6)** Except as described in paragraphs 71.5(6) “a” and “b,” the installation permit shall expire upon the earlier of the completion of the installation as described in the permit application or one year after issuance.

- a.* For a CPH, the installation permit shall expire upon completion of the last CPH jump.
- b.* For any conveyance, during the tenth month after issuance, and upon submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension may be granted at the discretion of the labor commissioner.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10]

**875—71.6(89A) Construction permits.** A construction permit authorizes the temporary, limited use of an elevator for purposes relating to construction or demolition.

**71.6(1)** Use of the elevator shall not begin until a construction permit has been issued by the division.

**71.6(2)** Application for a construction permit shall be in the format required by the labor commissioner and must include all the information requested by the labor commissioner and the fee specified by this chapter.

**71.6(3)** Upon submission of the completed application and fee, a state inspector shall be scheduled to inspect the elevator. Construction permits shall be issued only if the following criteria are met:

*a.* The elevator has been successfully tested pursuant to the requirements of ASME A17.1, Section 8.11.5.13; and

*b.* The applicable requirements of ASME A17.1, Section 5.10, are met.

**71.6(4)** The construction permit or a copy of the construction permit shall be posted conspicuously in a protective sleeve in the elevator car.

**71.6(5)** The construction permit shall expire 120 days after issuance. However, between 90 and 110 days after issuance and upon submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension of up to 90 days may be granted at the discretion of the labor commissioner.

**71.6(6)** Elevators with a construction permit but without an operating permit shall not be accessible to the general public.

**71.6(7)** Failure to comply with these provisions may result in the revocation of the construction permit.

**71.6(8)** An operating permit shall not be issued before construction and an acceptance inspection are complete.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

### **875—71.7(89A) Operating permits.**

**71.7(1)** Operation of equipment covered by this chapter without a current operating permit is prohibited, except as authorized by rules 875—71.6(89A), 875—71.8(89A), and 875—71.20(89A). If operation of a conveyance is prohibited under this rule, the labor commissioner may post notice on the conveyance that it is not to be used. The conveyance may be returned to service only after an operating permit for the conveyance has been issued or reissued.

**71.7(2)** Operating permits shall not be issued prior to successful completion of an inspection pursuant to rule 875—71.11(89A) and payment of all permit and inspection fees owed to the division.

**71.7(3)** Current operating permits or copies of current operating permits shall be conspicuously displayed as follows:

*a.* The operating permit for an elevator or CPH shall be posted in the car.

*b.* The operating permit for an escalator, dumbwaiter, wind tower lift, moving walk, or wheelchair lift shall be posted on or near the subject conveyance.

**71.7(4)** An operating permit shall expire 60 days after the first permit renewal inspection following the issuance of the operating permit, unless an earlier date is dictated by this rule.

**71.7(5)** An operating permit is automatically suspended when an alteration begins. The operating permit automatically resumes when the elevator passes an inspection pursuant to rule 875—71.11(89A).

**71.7(6)** An operating permit is automatically terminated when an imminent danger notice is posted on the conveyance.

**71.7(7)** Notwithstanding other provisions of this rule, at the discretion of the labor commissioner, a temporary operating permit may be issued for up to 30 days provided the inspection has been completed and no code violations were identified. Issuance of a temporary operating permit does not extend the expiration date of the conveyance's operating permit.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 0318C, IAB 9/5/12, effective 10/10/12; ARC 0574C, IAB 2/6/13, effective 3/13/13; ARC 0685C, IAB 4/17/13, effective 5/22/13]

**875—71.8(89A) Controller upgrade permits.** A controller upgrade permit may be issued to allow operation of an elevator while work to upgrade controls requires deactivation of the Phase I recall initiated by smoke sensing devices. Each elevator to be altered requires a separate controller upgrade permit. The duration of a controller upgrade permit shall not exceed 90 days. Each elevator in the group shall pass inspection pursuant to rule 875—71.11(89A) prior to being placed back into service.

**71.8(1)** A controller upgrade permit shall not be issued unless each of the following conditions is met:

*a.* Two or more elevators share a lobby at the level of the recall floor.

*b.* The project includes the installation of new elevator controllers in all of the elevators in the group.

c. Phase I fire recall initiated by a key-operated switch and all other controls shall be properly functioning for each elevator available for use.

d. There is a current alteration permit for the project.

e. A complete application for the controller upgrade permit and the fee established by this chapter have been submitted and accepted.

**71.8(2)** A controller upgrade permit shall not be construed to waive or excuse compliance with the requirements of any other governmental entity, including the department of public safety.

**71.8(3)** Upon the submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension of the permit for up to 60 days may be granted.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.9(89A) Alteration permits.**

**71.9(1)** Alteration shall not begin until an alteration permit has been issued by the division.

**71.9(2)** Application for an alteration permit shall be in the format required by the labor commissioner and shall include drawings and specifications of all planned changes and the fee specified by rule 875—71.16(89A).

**71.9(3)** Issuance of an alteration permit shall not be construed as a waiver or variance of any requirement of law.

**71.9(4)** The alteration permit or a copy of the alteration permit shall be conspicuously posted at the worksite.

**71.9(5)** If a complete installation permit application was submitted for a CPH pursuant to subrule 71.5(3), at least seven days' advance notice of each CPH jump shall be provided to the labor commissioner.

**71.9(6)** The alteration permit shall expire upon the earlier of the completion of the alteration as described in the permit application or one year after issuance. However, during the tenth month after issuance and upon submission to the labor commissioner of the fee set forth in this chapter, sufficient justification, and other required information, the labor commissioner may grant an extension of the alteration permit.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 2333C, IAB 1/6/16, effective 2/10/16]

**875—71.10(89A) Alterations.**

**71.10(1)** Alterations or changes shall comply with rule 875—72.13(89A) or rule 875—73.8(89A), as applicable.

**71.10(2)** A conveyance that is relocated shall be brought into compliance with all codes that are applicable at the time of relocation.

**71.10(3)** With the exception of replacing brushes on or adding brushes to escalators, all alterations of conveyances other than elevators shall require that the entire conveyance be brought into compliance with the current code.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 0685C, IAB 4/17/13, effective 5/22/13]

**875—71.11(89A) Inspections.** Pursuant to Iowa Code section 89A.12, inspections by the labor commissioner's designee shall be permitted at reasonable times with or without prior notice.

**71.11(1) Scope of inspections.**

a. *Comprehensive.* Periodic inspections shall be comprehensive. Elevators being transferred from construction permits to operating permits, previously dormant conveyances being returned to service, relocated conveyances, and new conveyances shall be inspected in their entirety prior to operation.

b. *Limited.* The scope of an inspection after an alteration shall be determined by rule 875—72.13(89A) or 875—73.8(89A), as applicable. However, if the inspector notices a safety hazard in plain view outside the altered components, or if the periodic inspection is due, the entire conveyance shall be inspected.

**71.11(2) *When inspections will occur.*** When the timing of two different types of inspection on a single conveyance coincide, a state inspector may perform both inspections in one visit.

*a. Periodic inspections.*

(1) Each construction elevator and CPH shall be inspected at intervals not to exceed three months. All other periodic conveyance inspections by state inspectors shall be conducted annually unless the labor commissioner determines resources do not allow annual inspections. If the labor commissioner determines quarterly inspections of construction elevators and CPHs and annual inspections of other state-inspected conveyances are not feasible due to insufficient resources, the labor commissioner shall determine the inspection schedule.

(2) Conveyance inspections by special inspectors shall be conducted at least annually.

*b. Acceptance inspections.* A CPH shall be inspected pursuant to the schedule in ANSI A10.4 – 2007, Chapter 26. For all other conveyances, an acceptance inspection shall occur:

(1) After each relocation,

(2) After each alteration,

(3) For a new installation, not less than two business days after a completed acceptance checklist is submitted by the conveyance installation company,

(4) Before an elevator subject to a construction permit receives an operating permit, and

(5) Before a previously dormant conveyance is returned to service.

*c. Other inspections.* Inspections may be made when the commissioner reasonably believes that a conveyance is not in compliance with the rules. Accidents, complaints, or requests for consultative inspections may result in inspections by the labor commissioner's designee.

**71.11(3) *Who may perform inspections.***

*a.* The labor commissioner's designee shall inspect altered conveyances, construction elevators, CPHs, previously dormant conveyances being returned to service, wind tower lifts exempted from ASME A17.1 by rule 875—72.12(89A), relocated conveyances, and new conveyances.

*b.* Except as noted in 71.11(3)“c,” annual inspections may be performed by state inspectors or special inspectors authorized by the labor commissioner pursuant to rule 875—71.12(89A).

*c.* An inspection report by a special inspector shall not be accepted as the required, annual inspection if the conveyance is under contract for maintenance, installation or alteration by the special inspector or the special inspector's employer, or if the property is owned or leased by the special inspector or the special inspector's employer.

**71.11(4) *Inspection standards.*** Inspections shall be performed in accordance with applicable safety codes or documents such as:

*a.* CCD;

*b.* ASME A17.1, Sections 8.10 and 8.11, except Section 8.11.1.1;

*c.* ANSI A10.4-2007;

*d.* Rule 875—72.12(89A) for wind tower lifts exempted from ASME A17.1 by rule 875—72.12(89A); or

*e.* ASME A18.1.

**71.11(5) *Inspection reports.***

*a.* All inspectors shall file inspection reports on forms approved by the commissioner within 30 days from the date of inspection and shall provide owners of conveyances with copies of completed inspection reports. The inspection report must separately list each unsafe condition and the applicable, specific code citation. Up to 30 days shall be allowed for correction of the unsafe conditions.

*b.* The owner may file a petition for reconsideration of an inspection report pursuant to 875—Chapter 69. The timely and proper filing of a petition for reconsideration extends the deadline for correction of the hazards that are subject to the petition for reconsideration.

**71.11(6) *Extension of time.*** The owner may petition the commissioner for up to 60 additional days to make the necessary corrections. The time frames set forth in subrule 71.11(7) may be adjusted by the labor commissioner as necessary to accommodate an extension of time.

**71.11(7) *Correction of unsafe conditions.*** In the absence of a determination on reconsideration or appeal that correction of hazards is not required, all unsafe conditions identified in the inspection report

shall be corrected. The labor commissioner shall verify correction of all unsafe conditions identified in the inspection report by sending a state inspector to reinspect the conveyance for the fee set forth in rule 875—71.16(89A), or by reviewing appropriate documentation such as a photograph, invoice, other verifiable document, or subsequent inspection report. The time frames set forth in this subrule may be accelerated at the request of the owner.

*a.* Promptly upon receipt of an inspection report listing unsafe conditions, the labor commissioner will send to the owner and the special inspector, if any, an abatement order. A copy of the inspection report shall be attached to the abatement order. Unless a special inspector conducted the inspection, the order may specify a period that ends no more than 45 days after the inspection during which the owner may submit written evidence that the unsafe conditions have been corrected. The abatement order shall:

- (1) Identify the equipment.
- (2) Demand that the unsafe conditions be corrected within the period set forth in the inspection report.
- (3) Set forth the consequences of failure to comply.

*b.* After the period specified on the inspection report has passed, the labor commissioner may cause a state inspector to verify correction of all unsafe conditions. If reinspection reveals no significant progress toward correcting the unsafe conditions, or the remaining unsafe conditions create significant safety concerns, the labor commissioner may serve a notice of intent to suspend, deny or revoke the operating permit.

*c.* The labor commissioner may issue an operating permit after receipt of the appropriate fee and verification that each unsafe condition identified in the inspection report has been corrected.

*d.* If written proof of correction was requested in the abatement order, but adequate proof was not received by the deadline set forth in the abatement order, the labor commissioner may send a second abatement order or cause a state inspector to inspect the conveyance. If the labor commissioner elects to send a second abatement order, it shall notify the owner that, if written proof of abatement is not received within 20 days, a state inspector may be sent to the site. Copies of the abatement order and the inspection report shall be attached to the second abatement order.

*e.* If a special inspector conducted the inspection, more than 45 days have passed since the deadline for correction of hazards, and an inspection report indicating the hazards are corrected has not been filed, the labor commissioner may contact the special inspector, send a second abatement order to the owner, or send a state inspector to inspect the conveyance. Copies of the abatement order and the inspection report shall be attached to a second abatement order.

*f.* If an inspection as described in paragraph 71.11(7) “*d*” or “*e*” reveals no significant progress toward correcting the unsafe conditions, and the remaining unsafe conditions create no significant safety concerns, the labor commissioner may extend the time for abatement of the unsafe conditions an additional 10 days or may serve a notice of intent to suspend, deny or revoke the operating permit. The labor commissioner may also post a notice prohibiting use of the conveyance pending abatement of the unsafe conditions listed in the inspection report.

*g.* Procedures for appeal of a notice of intent to suspend, deny or revoke an operating permit are set forth in 875—Chapter 69.

**71.11(8) *Imminent danger.*** If the labor commissioner determines that continued operation of a conveyance pending correction of unsafe conditions creates an imminent danger, the labor commissioner shall post notice on the conveyance that it is not to be used pending repairs. Use of a conveyance contrary to posted notice by the labor commissioner may result in additional legal proceedings pursuant to Iowa Code section 89A.10(3) or 89A.18. The conveyance may be returned to service only after the imminent danger has been corrected and the conveyance has passed a comprehensive inspection.

**71.11(9) *Interference prohibited.*** No person shall interfere with, delay or impede an inspector employed by the state during an inspection.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 1971C, IAB 4/29/15, effective 6/3/15]

**875—71.12(89A,252J,261,272D) Special inspector commissions.**

**71.12(1) Definition.** As used in this rule, “certificate of noncompliance” means:

- a. A certificate of noncompliance issued by the child support recovery unit, department of human services, pursuant to Iowa Code chapter 252J;
- b. A certificate of noncompliance issued by the college student aid commission pursuant to Iowa Code chapter 261; or
- c. A certificate of noncompliance issued by the centralized collection unit of the department of revenue pursuant to Iowa Code chapter 272D.

**71.12(2) Qualifications.**

- a. Each applicant must possess a high school diploma or general equivalency degree.
- b. Each applicant shall have at least three years of full-time work experience in the construction, installation, repair or inspection of conveyances.
- c. Each applicant shall be a CEI.
- d. Each applicant shall satisfactorily pass a division of labor services examination on Iowa procedures, Iowa policies, and all safety standards adopted by reference.
- e. Each applicant shall submit proof of insurance coverage insuring the applicant against liability for injury or death for any act or omission on the part of the applicant. The insurance policy shall be in an amount of not less than \$1,000,000 for bodily injury to or death of one person in any one accident, and in an amount of not less than \$5,000,000 for bodily injury to or death of two or more persons in any one accident, and in an amount of not less than \$100,000 for damage to or destruction of property in any one accident. The insurance coverage of the special inspector’s employer shall be considered to comply with this requirement if the coverage provides equivalent coverage for each special inspector.

**71.12(3) Application.** An applicant for a commission shall complete, sign, and submit to the division the form provided by the division with the required fee. The applicant shall include with the application proof that the applicant is a CEI.

**71.12(4) Expiration.** The commission expires when the commission is suspended or revoked by the labor commissioner or one year from issuance, whichever occurs earlier.

**71.12(5) Changes.** The special inspector shall notify the division at the time any of the information on the form or attachments changes.

**71.12(6) Denials.** The labor commissioner may refuse to issue or renew a special inspector’s commission for failure of the applicant to complete an application package, if the applicant is not a CEI, or for any reason listed in subrules 71.12(8) to 71.12(10).

**71.12(7) Investigations.** The labor commissioner may investigate for any reasonable cause related to special inspectors or special inspector applicants. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice at the times and in the places the labor commissioner directs. The labor commissioner may notify the organization that certified the special inspector as a CEI of the findings of an investigation.

**71.12(8) Reasons for probation.** The labor commissioner may issue a notice of commission probation when an investigation reasonably reveals that the special inspector filed inaccurate reports.

**71.12(9) Reasons for suspension.** The labor commissioner may issue a notice of commission suspension when an investigation reasonably reveals any of the following:

- a. The special inspector failed to submit and report inspections on a timely basis;
- b. The special inspector abused the special inspector’s authority;
- c. The special inspector misrepresented self as a state inspector or a state employee;
- d. The special inspector used commission authority for inappropriate personal gain;
- e. The special inspector failed to follow the division’s rules for inspection of object repairs, alterations, construction, installation, or in-service inspection;
- f. The special inspector committed numerous violations as described in subrule 71.12(8);
- g. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one’s self or another;
- h. The special inspector is no longer a CEI;
- i. The division received a certificate of noncompliance; or

*j.* The special inspector failed to take appropriate disciplinary actions against a subordinate special inspector who has committed repeated acts or omissions listed in paragraphs 71.12(9) “a” to “h.”

**71.12(10) *Reasons for revocation.*** The labor commissioner may issue a notice of revocation of a special inspector’s commission when an investigation reveals any of the following:

- a.* The special inspector filed a misleading, false or fraudulent report;
- b.* The special inspector failed to perform a required inspection;
- c.* The special inspector failed to file a report or filed a report which was not in accordance with the provisions of applicable standards;
- d.* The special inspector committed repeated violations as described in subrule 71.12(9);
- e.* The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one’s self or another;
- f.* The special inspector instructed, ordered, or otherwise encouraged a subordinate special inspector to perform the acts or omissions listed in paragraphs 71.12(10) “a” to “e”;
- g.* The special inspector is no longer a CEI; or
- h.* The division received a certificate of noncompliance.

**71.12(11) *Procedures.*** The following procedures shall apply except in the event of revocation or suspension due to receipt of a certificate of noncompliance. In instances involving receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J, 261, or 272D shall apply.

*a. Notice of actions.* The labor commissioner shall serve a notice on the special inspector by certified mail to an address listed on the commission application form or by other service as permitted by Iowa Code chapter 17A.

*b. Contested cases.* The special inspector shall have 20 days to file a written notice of contest with the labor commissioner. If the special inspector does not file a written contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.

*c. Hearing procedures.* The hearing procedures in 875—Chapter 1 shall govern.

*d. Emergency suspension.* Pursuant to Iowa Code section 17A.18A, if the labor commissioner finds that the public health, safety or welfare imperatively requires emergency action because a special inspector failed to comply with applicable laws or rules, the special inspector’s commission may be summarily suspended.

*e. Probation period.* A special inspector may be placed on probation for a period not to exceed one year for each incident causing probation.

*f. Suspension period.* A special inspector’s commission may be suspended up to five years for each incident causing a suspension.

*g. Revocation period.* A special inspector’s commission that has been revoked shall not be reinstated for five years.

*h. Concurrent actions.* Multiple actions may proceed at the same time against any special inspector.

*i. Revoked or suspended commissions.* Within five business days of final agency action revoking or suspending a special inspector commission, the special inspector shall surrender the special inspector’s commission card to the labor commissioner. The labor commissioner may notify the special inspector’s employer and the organization that certified the special inspector as a CEI of a revocation or suspension. [ARC 7841B, IAB 6/17/09, effective 7/22/09]

**875—71.13(89A) State employees.** Rescinded ARC 1971C, IAB 4/29/15, effective 6/3/15.

**875—71.14(89A) Safety tests.** Only safety test reports submitted on approved forms from elevator mechanics who are employed by authorized companies shall be considered to meet the requirements of this rule. The alternative test methods set forth at ASME A17.1, Rule 8.6.11.10, shall not be allowed as a substitute for a full-load safety test.

**71.14(1) *When safety tests will be performed.***

- a.* Safety tests shall be performed on new and altered installations before they are placed in service.

b. Safety tests shall be made on all conveyances pursuant to the schedules and procedures set forth in:

- (1) The maintenance control plan for wind tower lifts exempted from ASME A17.1 by rule 875—72.12(89A);
- (2) The CCD for conveyances covered by ASME A17.7-2007/CSA B44-07;
- (3) The columns pertaining to “periodic tests” in Table N-1 in the edition of ASME A17.1 currently adopted for new conveyances at rule 875—72.1(89A);
- (4) ASME A18.1(2003), Part 10; or
- (5) ANSI A10.4-2007, Section 26.4.

**71.14(2)** *How safety tests will be reported.* Within 30 days after completion of a safety test, the elevator mechanic shall file with the labor commissioner a report on an approved form and shall provide a copy of the form to the owner and to the witness, if applicable.

**71.14(3)** *How safety tests will be recorded.* The elevator mechanic shall attach a tag showing the date of the test, the elevator mechanic’s name, and the type of test performed.

a. On electric traction elevators, the elevator mechanic shall attach the tag to the safety-releasing carrier.

b. On hydraulic elevators, the elevator mechanic shall attach the tag to the disconnecting switch or the controller.

c. On wheelchair lifts, the elevator mechanic shall attach the tag to the disconnecting switch.

d. On other conveyances covered by these rules, the commissioner’s designee witnessing the acceptance safety test shall indicate the proper location of the tag. Subsequent test tags shall be attached in the same location.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 1766C, IAB 12/10/14, effective 1/14/15]

#### **875—71.15(89A) Authorized companies.**

**71.15(1)** Each year, authorized companies shall train their elevator mechanics who perform safety tests on safety test procedures.

**71.15(2)** For each conveyance owned by an authorized company, the owner shall obtain the services of a CEI who is not employed by the authorized company or an inspector employed by the state to witness the safety test.

**71.15(3)** To become authorized to perform safety tests, a company shall submit a copy of its procedures for performing safety tests. The labor commissioner shall review the procedures for adequacy and shall request modifications to the procedures or grant or deny the authorization.

**71.15(4)** Every five years or within six months after the board adopts a new edition of ASME, whichever is earlier, authorized companies shall submit revised safety test procedures for renewal of authorization. The labor commissioner shall review the procedures for adequacy and shall request modifications to the procedures or grant or deny the authorization.

**71.15(5)** Investigations. Investigations shall take place at the times and in the places the labor commissioner directs. The labor commissioner may investigate for any reasonable cause. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice.

**71.15(6)** Suspension. If the labor commissioner determines that a falsified safety test report was submitted by an elevator mechanic, the labor commissioner shall suspend the authorization of the elevator mechanic’s employer for six months. During the suspension, all safety tests performed by any employee of the authorized company shall be witnessed by a state inspector or a CEI who is not employed by the suspended authorized company.

**71.15(7)** Suspension procedures.

a. The labor commissioner shall notify an authorized company of its suspension by certified mail or by other service as permitted by Iowa Code chapter 17A.

b. The authorized company shall have 20 days to file a written notice of contest with the labor commissioner. If the authorized company does not file a written notice of contest in a timely manner,

the suspension shall automatically be effective. If the authorized company does file a written notice of contest in a timely manner, the hearing procedures in 875—Chapter 1 shall govern.

c. If the labor commissioner finds, pursuant to Iowa Code section 17A.18A, that public health, safety or welfare imperatively requires emergency action, the authorization may be summarily suspended.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.16(89A) Fees.** Except as noted in this rule, all fees are nonrefundable and due in advance.

**71.16(1) *Operating permits.*** The annual operating permit fee shall be \$75 per conveyance.

**71.16(2) *Periodic inspections.*** Fees shall be remitted to the division of labor services within 30 days of the date of inspection. The fees for periodic inspections shall be as follows:

- a. Construction elevator: \$200.
- b. Wind tower lift: \$225.
- c. Hand-powered elevator: \$90.
- d. Television tower elevator: \$500.
- e. Handicapped restricted use elevator: \$100.
- f. Other hydraulic elevator: \$100.
- g. Other traction elevator: \$150.
- h. Escalator: \$150.
- i. Dumbwaiter: \$90.
- j. Wheelchair lift: \$90.
- k. CPH.
  - (1) Annual: \$500.
  - (2) Quarterly: \$200.
- l. Moving walk: \$150.

**71.16(3) *Installation permits.*** The fees in this subrule cover the initial print review, installation permit, initial inspection and first-year operating permit. Each print revision submitted to the division shall be subject to an additional fee of \$100. The fees for new installations shall be as follows:

- a. Wind tower lift: \$500.
- b. Hydraulic elevator: \$750.
- c. Traction elevator: \$1000.
- d. Escalator: \$1000.
- e. Dumbwaiter: \$500.
- f. Wheelchair lift: \$500.
- g. CPH: \$500.
- h. Moving walk: \$500.

**71.16(4) *Alteration permits.***

a. The fee for any elevator alteration permit shall be \$500 and shall cover the initial print review, alteration permit, and initial inspection.

b. The fee for each CPH extension shall be \$150. The total fee required for all planned CPH extensions shall be submitted with the installation permit application pursuant to subrule 71.5(3).

c. The fee for an alteration permit shall be \$500 if the only alteration is the addition or replacement of an escalator skirt brush.

d. For all other conveyances, the fees for new installations shall apply to alterations.

**71.16(5) *Construction permits.*** The construction permit fee shall be \$200 per conveyance. This fee includes the fee for initial inspection.

**71.16(6) *Controller upgrade permits.*** The controller upgrade permit fee shall be \$250. This fee includes one inspection.

**71.16(7) *Consultative inspections.*** Consultative inspections may be performed at the discretion of the labor commissioner for \$125 per hour, including travel time, with a minimum charge of \$250.

**71.16(8) *Special inspector commission.*** The special inspector commission fee shall be \$60 annually.

**71.16(9) *Witness of safety tests.*** The fee for division employees to witness safety tests shall be \$125 per hour, including travel time, with a minimum charge of \$250.

**71.16(10) *Permit extensions.*** The fee to extend an installation permit, alteration permit, or construction permit shall be \$100.

**71.16(11) *Inspections outside of normal business hours.*** Inspections outside the normal business hours may be performed at the discretion of the labor commissioner. If the owner or contractor requests an inspection outside of normal business hours and the labor commissioner agrees to the schedule, an additional fee will be charged. The additional fee will be calculated at a rate of \$200 per hour, including travel time, with a minimum charge of \$400.

**71.16(12) *Reinspections.*** The fees for reinspections are \$400 for television tower elevators and CPHs, \$200 for wind tower lifts, and \$300 for all other conveyances.

**71.16(13) *Inspection for temporary removal from service.*** The inspection fee for temporary removal from service pursuant to rule 875—71.20(89A) shall be \$125 per hour, including travel time, with a minimum charge of \$250.

**71.16(14) *Fee waiver.***

*a.* When a state inspector combines in one visit two different types of inspection on a single conveyance, the commissioner may waive the lesser of the fees.

*b.* The fee for an alteration permit shall be waived by the commissioner if the only alterations covered by the permit application are required by rule 875—72.26(89A) or 875—73.27(89A). The fee waiver set forth in this paragraph does not eliminate the requirement to pay for an acceptance inspection or for an operating permit.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0318C, IAB 9/5/12, effective 10/10/12; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 1158C, IAB 10/30/13, effective 12/4/13; ARC 1972C, IAB 4/29/15, effective 6/3/15; ARC 1971C, IAB 4/29/15, effective 6/3/15]

**875—71.17(89A) *Publications available for review.*** Standards, codes, and publications adopted by reference in these rules are available for review in the office of the Division of Labor Services, 1000 E. Grand Avenue, Des Moines, Iowa 50319.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.18(89A) *Other regulations affecting elevators.*** Regulations concerning accessibility of buildings and conveyances available to the public are found at 661—Chapter 302. Regulations governing the safety and health of employees who work in and around elevators are found at 875—Chapters 2 to 26. Iowa Code chapter 91C and 875—Chapter 150 apply to companies that alter and install conveyances. No rule in 875—Chapters 71 to 73 shall be interpreted as creating an exemption, waiver, or variance from any otherwise applicable regulation or statute.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.19(89A) *Accidents.***

**71.19(1) *Reporting the accident.*** The owner shall immediately notify the commissioner of each personal injury accident requiring the service of a physician or causing disability exceeding one day or causing damage to the conveyance exceeding \$2,000. Notification shall be in writing and shall include the state identification number, owner, and description of accident.

**71.19(2) *Securing the accident site pending investigation.*** The removal of any part of the damaged conveyance or operating mechanism from the premises is forbidden until permission to do so is granted by the commissioner.

**71.19(3) *Putting the conveyance back into operation.*** When an accident involves the failure or destruction of any part of the conveyance or its operating mechanism, the use of the conveyance is forbidden until it has been made safe, until it has been reinspected, and until any repairs or alterations have been approved by the commissioner.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.20(89A) *Temporary removal from service.*** The requirements for an annual inspection, annual inspection fee, safety test, operating permit, and operating permit fee shall be temporarily

suspended for up to three years for an elevator in an unoccupied building if the requirements of this rule are met.

**71.20(1)** All elevator doors in unoccupied buildings shall be closed and locked. Hydraulic elevators shall be parked at the bottom of the hoistway. Traction elevators shall be parked at the top of the hoistway.

**71.20(2)** Upon request by the owner of an elevator in an unoccupied building, the labor commissioner shall send an inspector who is a state employee to confirm that the building is unoccupied and that the car and doors of the elevator have been properly secured. If the conditions set forth in subrule 71.20(1) are met, the inspector shall apply to the elevator a seal and a red tag marked with the words “Do Not Operate.”

**71.20(3)** One year after the inspection, the owner must file with the labor commissioner written confirmation that the status of the elevator and building have not changed, and the owner must file again two years after the inspection. Failure to comply with this requirement shall result in termination of the temporary suspension of the requirements for safety tests, inspections, and operating permits.

**71.20(4)** Prior to returning the elevator to service, and upon request of the owner, the labor commissioner may allow the elevator to be operated for 30 days for the sole purpose of performing safety tests and maintenance.

**71.20(5)** The owner must notify the labor commissioner at least two weeks before placing an elevator back into service and must arrange for an inspector who is a state employee to witness a safety test.

**71.20(6)** If at the end of three years the building is still unoccupied, suspension of the requirements for safety tests, inspections, and operating permits shall end without possibility of renewal.

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These rules are intended to implement Iowa Code chapters 89A, 252J, 261 and 272D.

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