

*State of Iowa*

**Iowa**  
**Administrative**  
**Code**  
**Supplement**

Biweekly  
January 8, 2014



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Published by the  
STATE OF IOWA  
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

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

### **Agriculture and Land Stewardship Department[21]**

Replace Chapter 65

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

Replace Chapter 5

### **Utilities Division[199]**

Replace Analysis

Replace Chapter 23

Replace Chapter 25

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

Replace Analysis

Replace Chapter 7

Replace Chapter 9

Replace Chapters 51 and 52

Replace Chapter 75

Replace Chapter 78

Replace Chapter 86

Replace Chapter 97

Replace Chapter 119

### **Professional Licensure Division[645]**

Replace Analysis

Replace Chapters 100 and 101

### **Transportation Department[761]**

Replace Analysis

Remove Reserved Chapters 144 to 149

Insert Chapter 144 and Reserved Chapters 145 to 149

### **Workforce Development Department[871]**

Replace Chapter 26

### **Labor Services Division[875]**

Replace Analysis

Remove Reserved Chapters 156 to 159

Insert Chapter 156 and Reserved Chapters 157 to 159



CHAPTER 65  
ANIMAL AND LIVESTOCK IMPORTATION

[Appeared as Ch 3, 1973 IDR]

[Prior to 7/27/88, see Agriculture Department 30—Ch 17]

**21—65.1(163) Definitions.**

*“Accredited veterinarian”* means a veterinarian licensed in the state of origin and approved by the United States Department of Agriculture (USDA), Animal and Plant Health Inspection Service (APHIS), to perform certain functions of federal and cooperative state-federal programs in accordance with the provision of Title 9 Code of Federal Regulations (CFR) §160 through §162.

*“Avian influenza- or exotic Newcastle disease-affected state”* or *“AI- or END-affected state”* means any state in which avian influenza subtype H5 or H7 or END virus has been diagnosed in poultry within the last 90 days prior to importation.

*“Domestic fowl”* means any member of the class Aves that is propagated or maintained under control of a person for commercial, exhibition, or breeding purposes or as a pet.

*“Feral swine”* means swine that are free-roaming.

*“Official individual identification”* means a unique individual identification that is secure and traceable including, but not limited to, a USDA-approved identification ear tag that conforms to the alphanumeric national uniform ear tagging system; a USDA-approved premises tattoo; a registered purebred tattoo; or identification that conforms to the National Animal Identification System. An owner’s private brand or tattoo, even though permanent and registered in the state of origin, is not acceptable official individual identification of an animal for the purpose of entry into Iowa.

*“Poultry”* means chickens, turkeys, domestic waterfowl, ratites, and domestic game birds, except doves and pigeons.

*“Pre-entry permit”* means a written or verbal authorization provided by the department prior to the importation of animals into Iowa. If required, a pre-entry permit number must be obtained and listed on the Certificate of Veterinary Inspection accompanying the animals.

*“Recognized slaughter establishment”* means a slaughtering establishment operating under the provisions of either the Federal Meat Inspection Act (21 U.S.C. 601 et seq.) or an equivalent state meat inspection program.

*“Specifically approved auction market”* means a stockyard, livestock market, buying station, concentration point, or any other premises under state or federal veterinary supervision where livestock are assembled for sale or sale purposes and which has been approved by USDA as provided in 9 CFR §71.20.

*“Transitional swine”* means swine that have been, or have had the potential to be, exposed to feral swine.

*“Vesicular stomatitis-affected state”* or *“VS-affected state”* means any state in which vesicular stomatitis (VS) virus serotype New Jersey or Indiana has been diagnosed within the last 60 days prior to animal importation.

**21—65.2(163) Pre-entry permits.**

**65.2(1)** Requests for permits should be directed to the Animal Industry Bureau, Department of Agriculture and Land Stewardship, Wallace State Office Building, Des Moines, Iowa 50319, or may be made by telephoning the bureau at (515)281-5547 during normal business hours (7:30 a.m. to 4:30 p.m.).

**65.2(2)** All permits shall be valid for one shipment only and shall be void 15 days after the date of issuance.

**65.2(3)** Pre-entry permits are required for:

- a. All Cervidae.
- b. All domestic fowl or poultry originating from an AI- or END-affected state.
- c. Captive wild-type swine.

*d.* Cattle and bison originating from states or zones not classified as tuberculosis-free and brucellosis-free.

[ARC 9151B, IAB 10/20/10, effective 9/20/10]

**21—65.3(163) General requirements and limitations.**

**65.3(1) *Restricted animals.*** The following animals are restricted from importation into the state:

*a.* No animal, including poultry or birds of any species, that is affected with, or that has been recently exposed to, any infectious, contagious or communicable disease or that originates from a quarantined area shall be shipped or in any manner transported or moved into Iowa, unless approved by the state veterinarian.

*b.* Prairie dogs (*Cynomys* sp.), tree squirrels (*Heliosciurus* sp.), rope squirrels (*Funisciurus* sp.), dormice (*Graphiurus* sp.), Gambian giant pouched rats (*Cricetomys* sp.), brush-tailed porcupines (*Atherurus* sp.), and striped mice (*Hybomys* sp.) are prohibited from importation into the state.

<sup>1</sup>**65.3(2) *Cleaning and disinfection of transportation vehicles.*** All stock cars and trucks used for hauling into the state of Iowa livestock (cattle, horses, sheep, goats, Cervidae, poultry and swine) for feeding, breeding, or stock purposes must be cleaned and disinfected before such shipments of livestock are loaded.

**65.3(3) *Certificate of Veterinary Inspection (CVI).*** Animals imported into the state must be accompanied by a Certificate of Veterinary Inspection, unless specifically exempted by this chapter.

*a.* A Certificate of Veterinary Inspection is a legible record accomplished on an official form of the state of origin, issued by a licensed accredited veterinarian and approved by the chief livestock health official of the state of origin; or an equivalent form of the United States Department of Agriculture (USDA) issued by a federally employed veterinarian. A Certificate of Veterinary Inspection may be an official paper form or an official approved electronic form.

*b.* A copy of the approved CVI shall be forwarded immediately to the chief livestock health official of the state of origin for approval and transmittal.

*c.* An approved CVI shall not be valid more than 30 days from the date of inspection of the animals.

*d.* The approved CVI must accompany the animals to their final destination in Iowa.

*e.* All information required on the CVI must be fully completed by the issuing veterinarian and must include the following:

- (1) Name and address of the consignor;
- (2) Name and address of the consignee;
- (3) Point of origin and premises identification, if assigned by the chief livestock health official in the state of origin;
- (4) Point of destination of the animals;
- (5) Date of examination;
- (6) Number of animals examined;
- (7) Official individual identification or group identification of all animals;
- (8) Sex, age, and breed of each animal;
- (9) Test results and herd or state status on diseases specified in this chapter;
- (10) Pre-entry permit number, if required; and
- (11) A statement by the issuing veterinarian that the animals identified on the CVI are free of signs of infectious or communicable disease.

**65.3(4) *Certification for vesicular stomatitis (VS).*** All hooved animals, including horses, ruminants, swine, and exotic and wild hooved animals, originating from a VS-affected state must be accompanied by an official Certificate of Veterinary Inspection which, in addition to meeting the requirements of subrule 65.3(3), includes the following statement: “All animals susceptible to Vesicular Stomatitis (VS) identified and included on this certificate have been examined and found to be free from clinical signs of VS, have not been exposed to VS, and, within the past 30 days, have not been within ten (10) miles of any site under quarantine for VS.”

<sup>1</sup> Objection filed 1/9/81; see “Objection” at the end of this chapter.

**21—65.4(163) Cattle and bison.****65.4(1) General.**

*a. Certificate of Veterinary Inspection (CVI).* All cattle and bison imported into the state must be accompanied by a CVI, except the following:

- (1) Cattle or bison consigned directly to a specifically approved auction market, and
- (2) Cattle or bison consigned directly to a recognized slaughter establishment.

*b. Identification.* All cattle and bison imported into the state must have official individual identification, except as otherwise provided in this rule.

**65.4(2) Requirements and limitations, general.**

*a.* Cattle or bison originating from herds or areas under quarantine shall not be admitted into the state.

*b.* Cattle or bison known to be infected with Johne's disease shall not be imported except to a recognized slaughter establishment and shall be accompanied by an owner-shipper statement that identifies the animals as positive to an official Johne's disease test. Such statement shall be delivered to the consignee, unless prior approval is obtained from the state veterinarian.

*c.* Cattle (beef-type) and bison steers and heifers more than 6 months of age but less than 18 months of age may be imported for feeding purposes without official individual identification and quarantined to the premises of destination. However, cattle and bison originating from a state which is not a tuberculosis-free state and heifers originating from a state which is not a brucellosis-free state are not eligible for this identification exemption. The CVI must contain the statement: "These animals are quarantined to the premises of destination until moved to slaughter."

**65.4(3) Testing.**

*a. Tuberculosis test.* Testing requirements for tuberculosis are as follows:

- (1) A tuberculosis test is not required for importation of cattle or bison provided that:
  1. The cattle or bison are native to, and originate from, an accredited tuberculosis-free herd (accredited herd number and date of last test must be listed on the CVI), state, or zone; or
  2. The cattle (beef-type) and bison are between the ages of 6 months and 18 months and are being imported for feeding purposes.
- (2) A negative tuberculosis test is required within 60 days prior to importation for cattle or bison six months of age or older that are not exempted by 65.4(3)"a"(1).
- (3) Cattle and bison less than 6 months of age that originate from a herd, state, or zone that is not accredited as tuberculosis-free or as modified accredited advanced must originate from a herd which has been whole-herd tested negative for tuberculosis within 12 months prior to importation.

*b. Brucellosis test.*

- (1) A brucellosis test is not required for importation of cattle or bison provided that:
  1. The cattle or bison are native to, and originate from, a certified brucellosis-free herd (herd number and date of last test shall be listed on the CVI), state, or area; or
  2. The cattle and bison are official calfhood vaccinates under 18 months of age; or
  3. The cattle and bison are steers or spayed heifers.
- (2) A negative brucellosis test is required within 30 days prior to importation for cattle or bison six months of age or older that are not exempted by 65.4(3)"b"(1).
- (3) Cattle and bison less than 6 months of age that originate from a herd, state or zone that is not certified brucellosis-free must originate from a herd which has been whole-herd tested negative for brucellosis within 12 months prior to importation.

(4) All brucellosis tests of cattle and bison shall be conducted by state or federal laboratories or by approved laboratories under the supervision of the chief livestock health official of the state of origin.

*c. Trichomoniasis test.* A bull must have a negative trichomoniasis test within 30 days prior to importation and have no subsequent sexual exposure. The trichomoniasis test is either one negative polymerase chain reaction (PCR) test or three consecutive weekly negative trichomoniasis foetus cultures. This testing requirement does not apply if the bull is:

- (1) Under the age of 24 months and listed on the Certificate of Veterinary Inspection as "virgin" or not having been sexually exposed to any female;

- (2) Being sent directly to slaughter or to an auction market and directly to slaughter; or
- (3) Temporarily in the state for a rodeo or exhibition and leaves after the event.

**65.4(4) Rodeo bulls.**

*a. Tuberculosis test.* A negative tuberculosis test is required within 12 months prior to importation.

*b. Brucellosis test.* A negative brucellosis test is required within 12 months prior to importation.

[ARC 9151B, IAB 10/20/10, effective 9/20/10; ARC 0230C, IAB 7/25/12, effective 8/29/12; ARC 1278C, IAB 1/8/14, effective 2/12/14]

**21—65.5(163,166D) Swine.**

**65.5(1) General.**

*a. Certificate of Veterinary Inspection (CVI).* All swine imported into the state, except swine consigned directly to a recognized slaughter establishment, swine consigned to a specifically approved auction market, or swine that are moved in accordance with an approved swine production health plan (SPHP), must be accompanied by a CVI.

*b. All swine imported into the state, except swine consigned directly to a recognized slaughter establishment, swine consigned to a specifically approved auction market, or swine that are moved in accordance with an approved swine production health plan (SPHP), must have official individual identification.*

*c. All swine imported into the state must originate from a herd or area not under quarantine.*

*d. Feral swine are not eligible for importation into the state.*

*e. Transitional swine must meet the requirements of 65.5(4) in addition to the general requirements. Transitional swine are swine that have been, or have had the potential to be, exposed to feral swine.*

**65.5(2) Breeding swine.**

*a. Brucellosis test.* All breeding swine imported into the state must:

(1) Originate from herds not known to be infected with, or exposed to, brucellosis and be accompanied by proof of a negative brucellosis test conducted within 30 days prior to importation; or

(2) Originate directly from a validated brucellosis-free state; or

(3) Originate directly from a validated brucellosis-free herd. The date of the last test and herd validation number must be included on the CVI.

*b. Pseudorabies test.* All breeding swine imported into the state must:

(1) Originate from a herd not known to be infected with, or exposed to, pseudorabies and be accompanied by proof of a negative pseudorabies test conducted within 30 days of importation; or

(2) Originate from a qualified pseudorabies negative (QN) herd (the date of last test and herd number shall be listed on the CVI); or

(3) Originate from a pseudorabies Stage IV or Stage V state.

**65.5(3) Feeder swine.**

*a. Brucellosis test.* Swine imported into the state for further feeding must originate from herds not known to be infected with, or exposed to, brucellosis.

*b. Pseudorabies test.* Swine imported into the state for further feeding must:

(1) Originate from herds not known to be infected with, or exposed to, pseudorabies and be accompanied by proof of a negative pseudorabies test conducted within 30 days prior to importation; or

(2) Originate from a qualified pseudorabies negative (QN) herd; or

(3) Originate from a pseudorabies Stage III, Stage IV or Stage V state.

**65.5(4) Captive wild-type and transitional swine.** Captive wild-type and transitional swine imported into the state must:

*a. Originate from herds not known to be infected with, or exposed to, brucellosis and be accompanied by proof of a negative brucellosis test conducted within 30 days prior to importation; and*

*b. Originate from herds not known to be infected with, or exposed to, pseudorabies and be accompanied by proof of a negative pseudorabies test conducted within 30 days prior to importation; and*

*c. Have a pre-entry permit from the state veterinarian.*

**65.5(5) *Swine for slaughter.*** All swine that are moved directly to a recognized slaughter establishment or to a specifically approved auction market for sale directly to a recognized slaughter establishment for immediate slaughter may be moved without restriction.

**21—65.6(163) Goats.**

**65.6(1) *General.***

*a.* Certificate of Veterinary Inspection (CVI). All goats imported into the state, except goats consigned directly to a recognized slaughter establishment and goats consigned to a specifically approved auction market, must be accompanied by a CVI.

*b.* All sexually intact goats imported into the state that are registered, are used for exhibition, or have resided on the same premises with or been commingled with sheep must be officially identified with either ear tags or tattoos that meet the requirements specified in 9 CFR §79.2 and §79.3 and the Scrapie Eradication Uniform Methods and Rules. All other goats imported into the state must have official individual identification.

*c.* All goats imported into the state must originate from a herd or area not under quarantine.

**65.6(2) *Breeding and dairy goats.***

*a. Brucellosis.*

(1) All sexually intact goats six months of age or older, except those for immediate slaughter, must:

1. Originate from a certified brucellosis-free herd (the date of the last test and certified herd number shall be listed on the CVI); or

2. Originate from a herd not known to be infected with, or exposed to, brucellosis and be accompanied by proof of a negative brucellosis test conducted within 30 days prior to importation.

(2) Sexually intact goats less than six months of age must originate from a herd which has been whole-herd tested negative for brucellosis within the last 12 months or must originate from a certified brucellosis-free herd (the date of the last test and certified herd number shall be listed on the CVI).

*b. Tuberculosis.*

(1) All goats six months of age or older must:

1. Originate from an accredited tuberculosis-free herd (the date of last test and accredited herd number shall be listed on the CVI); or

2. Originate from a herd which has been whole-herd tested negative for tuberculosis within 12 months of importation (the date of herd test shall be listed on the CVI); or

3. Originate from a herd not known to be infected with, or exposed to, tuberculosis and be accompanied by proof of a negative tuberculosis test conducted within 60 days of importation.

(2) Goats less than six months of age must originate from a herd which has been whole-herd tested negative for tuberculosis within the last 12 months or must originate from an accredited tuberculosis-free herd (the date of last test and accredited herd number shall be listed on the CVI).

**65.6(3) *Scrapie.*** Sexually intact goats from premises where scrapie has been known to exist within the last 60 months or sexually intact goats under surveillance for scrapie shall not be admitted into Iowa, except by permission of the state veterinarian for direct movement to a recognized slaughter establishment.

**21—65.7(163) Sheep.**

**65.7(1) *General.***

*a. Certificate of Veterinary Inspection (CVI).* All sheep imported into the state, except sheep consigned directly to a recognized slaughter establishment for immediate slaughter or sheep consigned to a specifically approved auction market, shall be accompanied by a CVI. For animals requiring identification, the CVI must include the official scrapie flock identification number(s) for the animal(s) listed or the official individual identification for each animal.

*b. Identification.*

(1) All sheep imported into the state must be officially, individually identified with ear tags that meet the requirements specified in 9 CFR §79.2 and §79.3 and the Scrapie Eradication Uniform Methods and Rules, unless exempted pursuant to 65.7(1)“b”(2).

(2) Exemption to identification requirements. Exemptions to requirements for individual identification of sheep include:

1. Sheep less than 18 months of age consigned directly to a recognized slaughter establishment; and
2. Wethers less than 18 months of age; and
3. Sheep less than 18 months of age consigned directly to an Iowa approved terminal feedlot. The CVI must list the approved terminal feedlot number for the feedlot.

**65.7(2) Restrictions and limitations.**

a. *Scabies*. Sheep from scabies-quarantined areas must meet federal regulations for interstate movement.

b. *Scrapie*. Sheep that are known to be scrapie-positive, suspect, high-risk, or exposed, or that originate from a known infected, source, exposed, or noncompliant flock may not be imported into the state unless:

- (1) The flock from which they originate has completed an approved scrapie flock cleanup plan, or
- (2) Prior permission has been granted by the state veterinarian.

**21—65.8(163) Equine.**

**65.8(1) General.**

a. Certificate of Veterinary Inspection (CVI). All equine imported into the state of Iowa shall be accompanied by a CVI.

b. Equidae which are positive to a brucellosis test or which show evidence of “poll evil” or “fistulous withers” whether draining or not shall not be allowed to enter the state for any purpose.

**65.8(2) Testing—equine infectious anemia (EIA).** All Equidae imported into the state must be accompanied by proof of a negative EIA serological test conducted within 12 months prior to importation, except foals under 6 months of age accompanied by their dams which meet the EIA test requirements. The name of the testing laboratory, laboratory accession number, and the date of test must appear on the CVI.

**21—65.9(163) Cervidae.**

**65.9(1) General.**

a. Definitions.

“*Cervidae*” means all animals belonging to the Cervidae family.

“*Chronic wasting disease*” or “*CWD*” means a transmissible spongiform encephalopathy of cervids.

“*CWD susceptible Cervidae*” means all species of Cervidae susceptible to chronic wasting disease, including whitetail deer, blacktail deer, mule deer, red deer, elk, moose, and related species and hybrids of these species.

b. Certificate of Veterinary Inspection (CVI). All Cervidae imported into the state shall be accompanied by a CVI.

c. All Cervidae imported into this state, except Cervidae consigned directly to a recognized slaughter establishment, must have a pre-entry permit. The permit number must be requested by the licensed accredited veterinarian signing the CVI and issued by the state veterinarian prior to movement of the Cervidae. The permit number must be recorded on the CVI.

**65.9(2) Chronic wasting disease.**

a. Cervidae originating from an area considered to be endemic for chronic wasting disease shall not be allowed entry into Iowa. Cervidae that originate from a herd that has had animal introductions from an area endemic to chronic wasting disease during the preceding five years shall not be allowed entry into Iowa.

b. CWD susceptible Cervidae shall only be allowed into Iowa from herds which are currently enrolled in and have satisfactorily completed at least five years in an official recognized CWD monitoring program. The CWD herd number, anniversary date, expiration date, and herd status for each individual animal must be listed on the CVI.

The following statement must be accurate and listed on the CVI:

“All Cervidae on this certificate originate from a CWD monitored or certified herd in which these animals have been kept for at least one year or were natural additions. There has been no diagnosis, sign, or epidemiological evidence of CWD in this herd for the past five years.”

c. Cervidae other than CWD susceptible Cervidae shall be allowed into the state only from herds which are currently enrolled in an official recognized CWD monitoring program. The CWD herd number, anniversary date, expiration date, and herd status for each individual animal must be listed on the CVI. The following statement must be accurate and listed on the CVI:

“All Cervidae on this certificate originate from a CWD monitored or certified herd and have not spent any time within the past 36 months in a zoo, animal menagerie or like facility, and have not been on the same premises as a cervid herd which has been classified as a CWD infected herd, exposed herd or trace herd.”

d. Each animal must have official individual identification, and all forms of identification must be listed on the certificate.

**65.9(3) Testing.**

a. *Tuberculosis test.* Herd status and Single Cervical Tuberculin (SCT) test (Cervidae) are according to USDA Tuberculosis Eradication in Cervidae Uniform Methods and Rules effective January 22, 1999.

(1) Cervidae six months of age or older imported into this state, except Cervidae imported directly to a recognized slaughter establishment, must:

1. Originate from a herd not under quarantine and be tested negative for tuberculosis (TB) within 90 days of importation by the Single Cervical Tuberculin (SCT) test (Cervidae) or by the Cervid TB Stat-Pak test; or

2. Originate from an accredited herd (Cervidae) or originate from a qualified herd (Cervidae) and be tested negative within 90 days of importation (the test dates and herd number shall be listed on the CVI).

(2) Cervidae less than 6 months of age imported into the state must originate from a herd which has been whole-herd tested negative for tuberculosis within the last 12 months or must originate from an accredited herd (Cervidae).

b. *Brucellosis test.*

(1) Cervidae six months of age or older imported into the state, except Cervidae imported directly to a recognized slaughter establishment, must:

1. Originate from a herd not under quarantine and be accompanied by proof of a negative brucellosis test conducted within 90 days of importation; or

2. Originate from a certified brucellosis-free cervid herd or a cervid class free status state (brucellosis). The date of the last test and herd number shall be listed on the CVI.

(2) Cervidae less than 6 months of age must originate from a herd which has been tested negative for brucellosis within the last 12 months or must originate from a certified brucellosis-free herd.

[ARC 7723B, IAB 4/22/09, effective 4/2/09; ARC 8951B, IAB 7/28/10, effective 9/1/10; ARC 0656C, IAB 3/20/13, effective 3/1/13]

**21—65.10(163) Dogs and cats.**

**65.10(1) General.**

a. Certificate of Veterinary Inspection (CVI). All dogs and cats imported into the state must be accompanied by a CVI indicating apparent freedom from disease or exposure to infectious or contagious disease, except dogs for exhibition and performing dogs entering for a limited period of time.

b. Dogs or cats originating from rabies-quarantined areas shall not be admitted.

**65.10(2) Rabies.**

a. *Cats.* No rabies vaccination is required.

b. *Dogs.* All dogs four months of age and older must have a current rabies vaccination with a USDA-approved rabies vaccine.

**21—65.11(163) Poultry, domestic fowl, and hatching eggs.**

**65.11(1) Certificate of Veterinary Inspection (CVI).** All poultry, domestic fowl, and their hatching eggs imported into the state, except poultry and domestic fowl consigned directly to a recognized slaughter establishment or a specifically approved auction market, must be accompanied by a CVI. For poultry and hatching eggs classified under provisions of the National Poultry Improvement Plan (NPIP), a VS Form 9-3, Report of Sales of Hatching Eggs, Chicks and Poults, may be substituted for the CVI.

**65.11(2) Restrictions and limitations, general.**

*a.* All poultry, domestic fowl, and their hatching eggs being imported into the state and not originating from an AI- or END-affected state must have a pre-entry permit issued by the Iowa Poultry Association. This permit may be obtained by calling (515)727-4701, extension 10.

*b.* Importations from an AI- or END-affected state.

(1) Approval. All domestic fowl, live poultry or poultry products from an AI- or END-affected state(s) may be considered for importation on a case-by-case basis following a risk assessment.

(2) Documentation. Poultry or poultry products must originate from a flock that is classified as AI clean under provision of the NPIP. The CVI must indicate that the poultry or poultry products originate from an AI- or END-negative flock and include a description of the birds, the test date, test results, and the name of the testing laboratory.

(3) Pre-entry permit. All domestic fowl, live poultry or poultry products originating from an AI- or END-affected state must have a pre-entry permit issued by the state veterinarian.

(4) Domestic fowl, live poultry or poultry products originating from a quarantined area shall not be allowed entry into the state.

**65.11(3) Testing.**

*a. Pullorum-typhoid test.*

(1) An official negative test for pullorum-typhoid is required within 30 days of importation for domestic fowl or live poultry or for the flock from which hatching eggs originate unless exempted pursuant to 65.11(3) "a"(2).

(2) Exemptions to the test requirements. No test is required for the following:

1. Imported domestic fowl, live poultry or hatching eggs originating from flocks classified under provisions of the NPIP as pullorum-typhoid clean.

2. Exotic birds or other pet birds.

3. Poultry consigned directly to a recognized slaughter establishment.

*b. Mycoplasma gallisepticum test—turkeys.* Live turkeys or turkey hatching eggs for importation must originate from a flock that has been tested annually and can be classified as U.S. mycoplasma gallisepticum clean as provided by the NPIP. Turkeys consigned directly to a recognized slaughter establishment are not affected by this subrule.

**21—65.12(163) Swine production health plan (SPHP).****65.12(1) General.**

*a. Swine production health plan (SPHP).* A swine production health plan is a written agreement developed for a swine production system and designed to maintain the health of the swine and detect signs of communicable disease. The plan must include all of the following:

(1) Address and contact information for all premises that are part of the swine production system and that receive or send swine in interstate commerce.

(2) Provisions for regular veterinary inspections of all swine maintained on the identified premises, at intervals no greater than 30 days, by the swine production system's licensed accredited veterinarian(s).

(3) Description of the record-keeping system of the swine production system.

(4) The signature of each official of each swine production system identified in the plan, including the swine production system's licensed accredited veterinarian(s), the state veterinarian, an APHIS representative, and the state animal health official from each state in which the swine production system has a premises.

(5) Acknowledgment that the managers of all the swine production system's premises listed in the plan have been notified that any failure of the participants in the swine production system to abide by

the provisions of the plan and the applicable provisions of 9 CFR Parts 71 and 85 constitutes a basis for the cancellation of the swine production health plan.

*b. Interstate swine movement report.* An interstate swine movement report is a paper or electronic document detailing interstate movement of animals within a swine production health system. The interstate swine movement report must include the following information:

(1) The name, location, and premises identification number of the premises from which the swine are to be moved.

(2) The name, location, and premises identification number of the premises to which the swine are to be moved.

(3) The date of movement.

(4) The number, age, and type of swine to be moved.

(5) A description of any individual identification or group identification associated with the swine.

(6) The name of the swine production system's licensed accredited veterinarian(s).

(7) The health status of the herd from which the swine are to be moved, including any disease of regulatory concern to the state or the United States Department of Agriculture (USDA) Animal Plant Health Inspection Service (APHIS).

(8) An accurate statement that swine on the premises from which the swine are to be moved have been inspected by the swine production system's licensed accredited veterinarian(s) within 30 days prior to the interstate movement, consistent with the dates specified by the premises' swine production health plan, and found free from signs of communicable disease.

*c. Swine production system.* A swine production system is an enterprise that consists of multiple sites of swine production (i.e., sow herds, nursery herds, and growing or finishing herds) that do not include a recognized slaughter facility or livestock market, that are connected by ownership or contractual relationships, and between which swine are moved while remaining under the control of a single owner or a group of contractually connected owners.

*d. Swine production system's licensed accredited veterinarian.* A swine production system's licensed accredited veterinarian is a licensed accredited veterinarian who is named in a swine production health plan for a premises within a swine production system and who performs inspection of such premises and animals and other duties related to the movement of swine in a swine production system.

**65.12(2) Identification of swine moving interstate within an SPHP.** Swine that are moved into the state within a swine production system to other than a recognized slaughter facility or a specifically authorized livestock market are not required to be individually identified when moved provided that the following requirements are met:

*a.* The swine may be moved interstate only to another premises identified in a valid swine production health plan for that swine production system.

*b.* The swine production system must operate under a valid swine production health plan in which both the sending and receiving states have agreed to allow the movement.

*c.* The swine must have been found free from signs of any communicable disease during the most recent inspection of the premises by the swine production system's licensed accredited veterinarian(s) within 30 days prior to movement.

*d.* Prior to the movement of any swine, the producer(s) moving swine must deliver the required interstate swine movement report to the following individuals identified in the swine production health plan:

(1) The swine production system's licensed accredited veterinarian for the premises from which the swine are to be moved.

(2) The state animal health officials for the state of origin of the swine.

(3) The state veterinarian for the state of destination of the swine.

(4) Individuals designated by the state animal health officials.

*e.* The receiving premises must not commingle swine received from different premises in a manner that prevents identification of the premises that sent the swine or groups of swine. This requirement may be met by use of permanent premises or individual animal identification, by keeping groups of animals

received from one premises physically separate from animals received from other premises, or by any other effective means.

*f.* For each premises, the swine production system must maintain for three years after their date of creation records that will allow a state animal health official to trace any animal on the premises back to its previous premises and must maintain copies of each swine production health plan signed by the producer, all interstate swine movement reports issued by the producer, and all reports the swine production system's accredited veterinarian(s) issues documenting the health status of the swine on the premises.

*g.* Each premises must allow state animal health officials access to the premises upon request to inspect animals and review records.

*h.* Every seven calendar days, each swine production system must send the state veterinarian a written summary that is based on the interstate swine movement report data and that shows how many animals were moved in the past seven calendar days, the premises from which they were moved, and the premises to which they were moved.

**65.12(3) Cancellation of SPHP.** The following procedures apply to cancellation of, or withdrawal from, a swine production health plan:

*a.* The state veterinarian may cancel the state's participation in a swine production health plan by giving written notice to all swine producers, APHIS representatives, accredited veterinarians, and other state animal health officials listed in the plan. Withdrawal shall be effective upon the date specified by the state veterinarian in the notice, but for shipments in transit, withdrawal shall become effective seven days after the date of such notice. Upon withdrawal of the state, the swine production health plan may continue to operate among the other states and parties that are signatory to the plan.

*b.* A swine production system may withdraw one or more of its premises from participation in the plan upon giving written notice to the state veterinarian, APHIS administrator, the accredited veterinarian(s), and all swine producers listed in the plan. Withdrawal shall be effective upon the date specified by the swine production system in the written notice, but for shipments in transit, withdrawal shall become effective seven days after the date of such notice.

*c.* The state veterinarian shall cancel a swine production health plan after determining that swine movements within the swine production system have occurred that were not in compliance with the swine production health plan or with other requirements of this chapter. Before a swine health production plan is canceled, the state veterinarian shall inform a representative of the swine production system of the reasons for the cancellation. The swine production system may appeal the cancellation in writing in accordance with Iowa Code chapter 17A and Iowa Administrative Code 21—Chapter 2. This cancellation shall continue in effect pending the completion of the proceeding, and any judicial review thereof, unless otherwise ordered by the state veterinarian.

**21—65.13(163) Penalties.** A person violating a provision of this chapter shall be subject to a civil penalty of at least \$100 but not more than \$1,000. In the case of a continuing violation, each day of the continuing violation is a separate violation. A person who falsifies a Certificate of Veterinary Inspection shall be subject to a civil penalty of not more than \$5,000 for each reference to an animal falsified on the certificate.

These rules are intended to implement Iowa Code chapter 163.

[Filed 12/3/64]

[Filed 4/13/76, Notice 2/9/76—published 5/3/76, effective 6/7/76]

[Filed 9/2/77, Notice 7/27/77—published 9/21/77, effective 10/26/77]

[Filed 11/21/80, Notice 10/15/80—published 12/10/80, effective 1/14/81]<sup>1</sup>

[Filed 8/13/82, Notice 7/7/82—published 9/1/82, effective 10/6/82]

[Filed emergency 10/8/85—published 11/6/85, effective 10/8/85]

[Filed 12/13/85, Notice 11/6/85—published 1/1/86, effective 2/5/86]

[Filed emergency 4/6/87—published 4/22/87, effective 4/6/87]

[Filed emergency 5/15/87—published 6/3/87, effective 7/1/87]

[Filed emergency 7/8/88 after Notice 6/1/88—published 7/27/88, effective 7/8/88]

[Filed 10/18/90, Notice 7/25/90—published 11/14/90, effective 1/1/91]  
[Filed 6/17/94, Notice 5/11/94—published 7/6/94, effective 8/10/94]  
[Filed 8/25/94, Notice 7/20/94—published 9/14/94, effective 10/19/94]  
[Filed 2/21/96, Notice 1/17/96—published 3/13/96, effective 4/17/96]  
[Filed 5/29/96, Notice 4/24/96—published 6/19/96, effective 7/24/96]  
[Filed 11/27/96, Notice 10/23/96—published 12/18/96, effective 1/22/97]  
[Filed 11/7/03, Notice 10/1/03—published 11/26/03, effective 12/31/03]  
[Filed emergency 7/2/04—published 7/21/04, effective 7/2/04]  
[Filed 5/6/05, Notice 3/30/05—published 5/25/05, effective 6/29/05]  
[Filed emergency 4/11/08—published 5/7/08, effective 4/11/08]  
[Filed 10/2/08, Notice 8/27/08—published 10/22/08, effective 11/26/08]  
[Filed Emergency ARC 7723B, IAB 4/22/09, effective 4/2/09]  
[Filed ARC 8951B (Notice ARC 8754B, IAB 5/19/10), IAB 7/28/10, effective 9/1/10]  
[Filed Emergency After Notice ARC 9151B (Notice ARC 8985B, IAB 8/11/10), IAB 10/20/10,  
effective 9/20/10]  
[Filed ARC 0230C (Notice ARC 0140C, IAB 5/30/12), IAB 7/25/12, effective 8/29/12]  
[Filed Emergency ARC 90656C (Notice ARC 0642C, IAB 3/6/13), IAB 3/20/13, effective 3/1/13]  
[Filed ARC 1278C (Notice ARC 1179C, IAB 11/13/13), IAB 1/8/14, effective 2/12/14]

<sup>1</sup> Objection to 30 IAC 17.1(3) filed 1/9/81; subrule renumbered 21—65.1(3) IAC 7/27/88; renumbered as 65.3(2) IAB 5/25/05.

## OBJECTION

At its January 9, 1981 meeting the administrative rules review committee voted the following objection:

The committee objects to subrule 30 IAC 17.1(3)\* on the grounds it is unreasonable. The subrule appears as part of ARC 1630 in III IAB 12 (12/10/80) and requires all livestock vehicles to be cleaned and disinfected before they carry shipments into the state. The committee feels this provision is impossible to enforce because it relates to activities that occur outside of Iowa jurisdiction.

\* Renumbered 21—65.1(3) IAC 7/27/88; renumbered as 65.3(2) IAB 5/25/05.

## REGULATION OF INSURERS

## CHAPTER 5

## REGULATION OF INSURERS—GENERAL PROVISIONS

[Prior to 10/22/86, Insurance Department [510]]

**191—5.1(507) Examination reports.** Upon the completion of an examination a copy of the report will be furnished the company, association or society examined, whereupon the company, association or society will have 20 days in which to determine whether or not it will demand a hearing before the commissioner of insurance. If a hearing is desired, then and in that event the company, association or society shall, within said 20 days, file with the commissioner of insurance a written application, attaching thereto the specific grounds upon which a hearing is desired. Within a reasonable time after the receipt of said application, the commissioner will fix a date for the hearing and notify the company, association or society thereof. Upon the completion of the hearing, or as soon as convenient thereafter, the commissioner shall render the commissioner's decision, either orally or in writing at the commissioner's discretion and file said report as part of the records in the division.

This rule is intended to implement Iowa Code sections 505.8 and 507.2.

**191—5.2(505,507) Examination for admission.** Any foreign or alien insurance company seeking to be admitted to do business in the state of Iowa shall, at the discretion of the division of insurance, be subject to either or both of the following:

1. An on-site examination by the division;
2. A desk examination, if the applicant provides a financial examination report prepared by the insurance regulatory body of the applicant's state or country of domicile. The examination report must be certified by the issuing regulatory body and must have an effective date of not more than two years prior to the date of application for admission.

This rule is intended to implement Iowa Code section 507.2.

**191—5.3(507,508,515) Submission of quarterly financial information.** All insurers, corporations, associations, and other entities required to submit annual financial statements to the commissioner shall also submit a short form quarterly financial statement within 45 days of the close of each calendar quarter on a form as specified by the commissioner. Upon request of the commissioner an exhibit showing a count of policies in force by line of business as of the close of the quarter shall be submitted with the quarterly report. The quarterly financial statements shall also be filed with the National Association of Insurance Commissioners.

This rule is intended to implement Iowa Code section 507.2 and Iowa Code chapters 508 and 515.

**191—5.4(505,508,515,520) Surplus notes.** Surplus notes are recognized by the commissioner for both stock and mutual insurers. All payments of principal and interest on these notes require the prior approval of the commissioner.

**191—5.5(505,515,520) Maximum allowable premium volume.** A domestic property/casualty insurer shall not cause the ratio of its net written premiums to its surplus as regards policyholders to exceed three to one without the approval of the commissioner of insurance.

**191—5.6(505,515,520) Treatment of various items on the financial statement.** An admitted insurer shall at all times show the value of the following items on its financial statements in the following manner unless a different treatment is authorized by the state where the insurer is domiciled:

**5.6(1) Real estate.** At amortized cost.

**5.6(2) Stocks.** At market value as determined by the Securities Valuation Office of the National Association of Insurance Commissioners.

**5.6(3) Bonds.** At amortized cost, unless directed otherwise by the commissioner of insurance.

**5.6(4) Artwork.** Nonadmitted.

**5.6(5) *Other assets not listed.*** As treated by the applicable accounting practices and procedures manual of the National Association of Insurance Commissioners.

**5.6(6) *Liabilities.*** Liabilities, including active life reserves, unearned premium reserves, and liabilities for claims and losses unpaid and for incurred but not reported claims. As determined by the applicable accounting practices and procedures manual of the National Association of Insurance Commissioners.

These rules are intended to implement Iowa Code sections 505.8, 515.20, 515.49, 515.63, and 520.21.

**191—5.7(505) Ordering withdrawal of domestic insurers from states.** Upon a finding, after notice and opportunity for hearing, of substantial likelihood of future financial impairment of a domestic insurer due to persistent operating losses in any line of business in any state where the insurer does business, the commissioner may order a domestic insurer to withdraw and cease doing business in that line of business in that state or in the alternative, order the insurer to withdraw and cease doing business in all lines, pending further order. For the purposes of this rule, impaired or threatened financial solvency is deemed to exist where an insurer experiences a reduction of 5 percent or greater in surplus in any 12-month period from all cases, including the regulatory environment in a state.

**191—5.8(505) Monitoring.** Upon request of the commissioner, a domestic insurer shall provide all relevant information as to its business in any state identified by the commissioner and found by the commissioner to have a consistently oppressive and confiscatory regulatory environment: The commissioner's request shall identify the state and shall include a basis for the commissioner's findings that the state has a consistently oppressive and confiscatory regulatory environment.

**191—5.9(505) Rate and form filings.** Insurers doing business in Iowa shall file rates and forms in accordance with applicable law and with 191—Chapters 20, 30, 31, 34, 35, 36, 37, and 39, as applicable.

**191—5.10(511) Life companies—permissible investments.**

**5.10(1)** The phrase “preferred dividend requirements as of the date of acquisition” in Iowa Code section 511.8(6) is construed to include the dividend requirements of a new issue. Consequently, a new preferred issue will qualify if the net earnings of the corporation for each of the five preceding years have been not less than one and one-half times the sum of the annual fixed charges, contingent interest and the annual preferred dividend requirements including the new issue.

**5.10(2)** The phrase “the obligations are adequately secured and have investment qualities and characteristics wherein the speculative elements are not predominant” in Iowa Code section 511.8(5) means “investment grade” as defined in 191—subrule 22.1(4). As a result, except as permitted by the commissioner in exceptional circumstances, corporate obligations must be “investment grade” in order to meet legal reserve requirements unless the other requirements of Iowa Code section 511.8(5) “a” regarding the financial condition of the issuer of the obligation are met. The legal reserve investment limitations of Iowa Code section 511.8 regarding less than investment grade obligations, but not the deposit requirements of that section, are applicable to foreign insurers.

This rule is intended to implement Iowa Code section 511.8(5).

**191—5.11(511) Investment of funds.**

*Ruling No. R21. By Division.*

The Forty-first General Assembly of Iowa amended [508 & 511](511.8) of the Code of 1924, relating to the investment of funds by life insurance companies organized in this state, by adding to paragraph one of said section the following:

“Or federal farm loan bonds issued under the Act of Congress, approved July 17, 1916.”

Doubt has arisen in the minds of company officials as to whether or not the amendment in question authorizes life insurance companies organized in Iowa to invest their funds in bonds issued by joint stock land banks.

In a written opinion of the attorney general of Iowa, bearing date May 25, 1925, it is held that, inasmuch as joint stock land banks were created under the Act of Congress approved July 17, 1916, bonds issued by such banks are included in the amendment aforesaid.

Therefore, it is the ruling of this division that such bonds are a legal investment for life insurance companies organized in this state. However, said amendment is not effective until July 4, 1925, and until said date no such investments should be made.

**191—5.12(515) Collateral loans.** The collateral pledged to secure a loan must qualify as a legal investment for insurance companies before the loan it secures may so qualify [section 515.35(7)]. The statute provides that a company may not invest in excess of 30 percent of its capital and funds in stocks and not more than 10 percent of its capital and surplus in the stock or bonds, or both, of any one corporation.

Normally, a loan is little better than the collateral securing it. Therefore, in order to conform to the intent and purpose of the legislature it would appear that the same limitations should likewise be applied to the stock securing a collateral loan. The statute also provides that the value of the collateral must exceed the amount of the loan by 10 percent.

**191—5.13(508,515) Loans to officers, directors, employees, etc.** No insurance company or association of any kind, domiciled in the state of Iowa, shall loan any portion of its funds to an officer, director, stockholder, employee or any relative or immediate member of the family of an officer or director.

The provisions of Iowa Code sections 508.8 and 511.12 shall likewise be applicable to fire and casualty companies.

**191—5.14(515) Salvage as an asset.** Rescinded IAB 11/25/92, effective 11/6/92.

**191—5.15(508,512B,514,514B,515,520) Accounting practices and procedures manual and annual statement instructions.**

**5.15(1) Purpose.** The purpose of this rule is to adopt the National Association of Insurance Commissioners' accounting practices and procedures manual which has been revised to provide a comprehensive guide to statutory accounting principles, commonly referred to as the "codification project." Additionally, the rule adopts by reference the annual statement instructions promulgated by the National Association of Insurance Commissioners.

**5.15(2) Financial statements.** Effective January 1, 2001, all information reflected in the financial statements of insurance companies authorized to do business in Iowa shall conform with the accounting practices and procedures manual of the National Association of Insurance Commissioners.

All annual financial statements filed with the commissioner shall conform to the annual statement instructions and manuals promulgated by the National Association of Insurance Commissioners.

This rule is intended to implement Iowa Code sections 508.11(43), 512B.24, 514.9, 514B.12, 515.63 and 520.10.

**191—5.16 to 5.19** Reserved.

**191—5.20(508) Computation of reserves.** Iowa life insurance companies may report the nonadmitted excess item to this division on the basis of the true reserve instead of the mean reserve as has been the practice in the past. Under the true reserve system there will be no excess excepting in the case of indebtedness in excess of policy liabilities. The true reserve system eliminates all excess on account of due and deferred premiums, but there may be an excess equal to or in excess of the loading depending upon what premium the note represents, and how long it has been running when a premium note is taken for the gross premiums or when there is an overloan.

This concession is made to Iowa companies with the conviction that it removes many of the defects and disadvantages of the present practice of requiring the excess of the mean reserve.

As a corollary to the proposed system of determining this excess item, the business of the company must be reported upon a strictly paid for basis.

This division will not require that policies be lapsed if premium is not paid within a limited time after the due date, but no credit for an uncollected premium may be taken if more than 60 days past due, unless a premium note of the proper form has been taken therefor.

UNEARNED PREMIUM RESERVES ON MORTGAGE GUARANTY INSURANCE POLICIES

**191—5.21(515C) Unearned premium reserve factors.** In the case of premiums paid in advance on ten-year policies, mortgage guaranty insurers shall apply the following annual factors or comparable monthly factors in determining the unearned premium reserve:

Years policy is in force	Unearned premium factor	Years policy is in force	Unearned premium factor
1	81.8	6	18.2
2	65.5	7	10.9
3	50.9	8	5.5
4	38.2	9	1.8
5	27.3	10	-0-

**191—5.22(515C) Contingency reserve.** From the premium remaining after applying the appropriate factor from the table in 191—5.21(515C) above, there shall be maintained a contingency reserve as prescribed in Iowa Code section 515C.4.

These rules are intended to implement Iowa Code sections 515C.3 and 515C.4.

**191—5.23(507C) Standards.** The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors or the general public. The commissioner may consider:

**5.23(1)** Adverse findings reported in financial condition and market conduct examination reports.

**5.23(2)** The National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports.

**5.23(3)** The ratios of commission expense, general insurance expense, policy benefits and reserve increases to annual premium and net investment income which could lead to an impairment of capital and surplus.

**5.23(4)** The insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to ensure the company's ability to meet its outstanding obligations as they mature.

**5.23(5)** The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

**5.23(6)** The insurer's operating loss in the last 12-month period or any shorter period of time including, but not limited to: net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders reduces such insurer's remaining surplus as regards policyholders below the minimum required.

**5.23(7)** Whether any affiliate, subsidiary or reinsurer of the insurer is insolvent as defined in Iowa Code section 507C.2(11), is threatened with insolvency, or is delinquent in payment of its monetary or other obligation.

**5.23(8)** Contingent liabilities, pledges or guarantees which either individually or collectively involve a total amount which, in the opinion of the commissioner, may affect the solvency of the insurer.

**5.23(9)** Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

**5.23(10)** The age and collectibility of receivables.

**5.23(11)** Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position.

**5.23(12)** Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry.

**5.23(13)** Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

**5.23(14)** Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner.

**5.23(15)** Whether the company has experienced or will experience in the foreseeable future cash flow or liquidity problems.

**5.23(16)** Rescinded IAB 7/10/91, effective 6/21/91.

This rule is intended to implement Iowa Code sections 507C.9, 507C.12 and 507C.17.

#### **191—5.24(507C) Commissioner's authority.**

**5.24(1)** For the purposes of making a determination of an insurer's financial condition under this rule, the commissioner may:

- a.* Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired or otherwise subject to a delinquency proceeding;
- b.* Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;
- c.* Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or
- d.* Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

**5.24(2)** If the commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or the general public, then the commissioner may issue an order requiring the insurer to:

- a.* Reduce the total amount of present and potential liability for policy benefits by reinsurance;
- b.* Reduce, suspend or limit the volume of business being accepted or renewed;
- c.* Reduce general insurance and commission expenses by specified methods;
- d.* Increase the insurer's capital and surplus;
- e.* Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;
- f.* File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;
- g.* Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;
- h.* Document the adequacy of premium rates in relation to the risks insured;
- i.* File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such format as promulgated by the commissioner.

**5.24(3)** Any insurer subject to an order under subrule 5.24(2) may request, pursuant to rule 191—3.4(17A), review of that order. Any ensuing hearing shall not be open to the public, unless the insurer requests otherwise.

This rule is intended to implement Iowa Code sections 507C.9, 507C.12 and 507C.17.

#### **191—5.25(505) Annual audited financial reports.** Rescinded IAB 11/17/10, effective 12/22/10.

**191—5.26(508,515) Participation in the NAIC Insurance Regulatory Information System.**

**5.26(1)** This rule applies to all domestic, foreign and alien insurers who are authorized to transact business in this state.

**5.26(2)** Each domestic, foreign and alien insurer, except entities organized under Iowa Code chapters 512A, 512B, 514, 514B, 518 and 518A and those which write only in this state, who is authorized to transact insurance in this state shall annually on or before March 1 of each year, file with the National Association of Insurance Commissioners (NAIC) a copy of its annual statement convention blank, along with such additional filings as prescribed by the insurance commissioner for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the NAIC.

Foreign insurers that are domiciled in a state which has a law substantially similar to the requirement in the previous sentence shall be deemed in compliance with this rule.

**5.26(3)** Members of the NAIC, their duly authorized committees, subcommittees, and task forces, their delegates, NAIC employees, and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating the information developed from the filing of the annual statement convention blanks shall be deemed to be acting on behalf of the commissioner by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required under this rule.

**5.26(4)** All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the insurance division by the NAIC Insurance Regulatory Information System are confidential as provided in 191—subrule 1.3(11), paragraph “c.”

**5.26(5)** The commissioner may suspend, revoke or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due or within any extension of time which the commissioner, for good cause, may have granted.

**5.26(6)** Electronic filing. The annual financial statement filings required of domestic insurers pursuant to Iowa Code sections 508.11 and 515.63 and the quarterly statement filings required pursuant to rule 191—5.3(507,508,515) must be filed electronically with the National Association of Insurance Commissioners. Electronic filing shall include filing via the Internet or by diskette. The electronic filing must be prepared in accordance with the NAIC Directive to Companies, Coding Conventions, Field Names and Definitions, Data Elements, and Reporting Requirements for Annual/Quarterly Statement Submission on Diskettes. Electronic filings are in addition to and due at the time of the filing of the annual/quarterly financial statement blank with the National Association of Insurance Commissioners. Diskette filings do not need to be filed with the insurance division unless the insurer is directed by the insurance commissioner to submit the filing(s) on diskette. This diskette filing requirement does not apply to entities organized pursuant to Iowa Code chapters 512A, 512B, 514, 514B, 518, and 518A.

This rule is intended to implement Iowa Code sections 508.11 and 515.63.

**191—5.27(508,515,520) Asset valuation.**

**5.27(1)** All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

- a. If purchased at par, at the par value.
- b. If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made or, in lieu of such method, according to such accepted method of valuation as is approved by the division.
- c. Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage or express charges paid in the acquisition of such securities.

**5.27(2)** The division shall have full discretion in determining the method of calculating values according to the procedures set forth in this rule, but no such method or valuation shall be inconsistent

with any applicable valuation or method used by insurers in general, or any method formulated or approved by the National Association of Insurance Commissioners or its successor organization.

**5.27(3)** Securities, other than those referred to in subrule 5.27(1), held by an insurer shall be valued, in the discretion of the division, at their market value, or at their appraised value, or at prices determined by it as representing their fair market value.

**5.27(4)** Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the division and in accordance with such method of valuation as it may approve.

**5.27(5)** Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of the net value of the subsidiary as based upon only those assets of the subsidiary which would be eligible under Iowa Code section 521A.2 had investment of the funds of the insurer been made directly.

**5.27(6)** No valuations under this rule shall be inconsistent with any applicable valuation or method formulated or approved by the National Association of Insurance Commissioners.

**191—5.28(508,515,520) Risk-based capital and surplus.** Capital and surplus requirements in Iowa Code chapters 508, 518 and 520 are minimums. The commissioner retains the discretion to require greater amounts than set forth in those chapters when the risk-based circumstances of a particular insurer, including the type, nature and volume of business being written, require it.

**191—5.29(508,515) Actuarial certification of reserves.** An opinion on life and health policy and claim reserves and property and casualty loss and loss adjustment expense reserves by a qualified actuary is required in the annual statement blank for all domestic insurers under the terms and conditions contained in the annual statement instructions handbook of the National Association of Insurance Commissioners. All other provisions of the handbook shall be applicable to annual and quarterly financial statements filed with the division.

These rules are intended to implement Iowa Code sections 508.5, 508.9, 508.10, 508.11, 515.8, 515.10, 515.12 and 515.63.

**191—5.30(515) Single maximum risk—fidelity and surety risks.** No insurance company is permitted under the limitations of Iowa Code section 515.49 to expose itself to any risk on a fidelity or surety bond in excess of 10 percent of its surplus to policyholders, unless such excess shall be reinsured in accordance with the provisions of the statute.

**191—5.31(515) Reinsurance contracts.** No credit will be given the ceding insurer for reinsurance made, ceded, or renewed unless the reinsurance agreements (treaty, facultative or otherwise) substantially provide, or are amended by a supplemental contract to read in substance as follows:

In consideration of the continuing benefits to accrue hereunder to the assuming insurer, the assuming insurer hereby agrees that, as to all reinsurance made, ceded, or renewed the reinsurance shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer.

**191—5.32(511,515) Investments in medium grade and lower grade obligations.**

**5.32(1) Reason for promulgation.** The insurance division is concerned that changes in economic conditions and other market variables could adversely affect domestic insurers having a high concentration of these investments. Accordingly, the division has concluded that a limitation on the percentage of total admitted assets that a domestic insurer may prudently invest in such obligations is reasonable, necessary and required in order to carry out the division's responsibilities under relevant statutory law.

The division understands that medium grade and lower grade obligations can have a place in a well diversified portfolio. However, it is also understood that the special risks associated with these investments require a high degree of management even when they are held within an aggregate limit. While this rule will leave all domestic insurers with authority to invest a substantial portion of their assets

in medium grade and lower grade obligations, the prudent management of the attendant risk will remain an essential element of such investing.

**5.32(2) Purposes.** The purposes of this rule are:

*a.* To protect the interests of the insurance-buying public by establishing limitations on the concentration of medium grade and lower grade obligations in which a domestic insurer can invest;

*b.* To regulate the acts and practices of domestic insurers with respect to the concentration of investments in medium grade and lower grade obligations. An insurer's obligations of these classifications shall not exceed the greater of those allowed in subrule 5.10(2) or Iowa Code section 515.35(4) "e," whichever is applicable, or this rule.

**5.32(3) Definitions.** As used in this rule:

"*Admitted assets*" means the amount thereof as of the last day of the most recently concluded annual statement year, computed in accordance with rule 191—5.6(505,515,520).

"*Aggregate amount*" of medium grade and lower grade obligations means the aggregate statutory statement value thereof.

"*Institution*" means a corporation, a joint-stock company, an association, a trust, a business partnership, a business joint venture or similar entity.

"*Lower grade obligations*" means obligations which are rated four, five or six by the Securities Valuation Office of the National Association of Insurance Commissioners.

"*Medium grade obligations*" means obligations which are rated three by the Securities Valuation Office of the National Association of Insurance Commissioners.

**5.32(4) Provisions.**

*a.* No domestic insurer shall acquire, directly or indirectly, any medium grade or lower grade obligation of any institution if, after giving effect to any such acquisition, the aggregate amount of all medium grade and lower grade obligations then held by the domestic insurer would exceed 20 percent of its admitted assets provided that:

(1) No more than 10 percent of its admitted assets consists of obligations rated four, five or six by the Securities Valuation Office;

(2) No more than 3 percent of its admitted assets consists of obligations rated five or six by the Securities Valuation Office;

(3) No more than 1 percent of its admitted assets consists of obligations rated six by the Securities Valuation Office. Attaining or exceeding the limit of any one category shall not preclude an insurer from acquiring obligations in other categories subject to the specific and multicategory limits.

*b.* No domestic insurer may invest more than an aggregate of 1 percent of its admitted assets in medium grade obligations issued, guaranteed or insured by any one institution, nor may it invest more than one-half of 1 percent of its admitted assets in lower grade obligations issued, guaranteed or insured by any one institution. In no event, however, may a domestic insurer invest more than 1 percent of its admitted assets in any medium or lower grade obligations issued, guaranteed or insured by any one institution.

*c.* Nothing contained in this rule shall prohibit a domestic insurer from acquiring any obligations which it has committed to acquire if the insurer would have been permitted to acquire that obligation pursuant to this rule on the date on which such insurer committed to purchase that obligation.

*d.* Notwithstanding the foregoing, a domestic insurer may acquire an obligation of an institution in which the insurer already has one or more obligations if the obligation is acquired in order to protect an investment previously made in the obligations of the institution, provided that all such acquired obligations shall not exceed one-half of 1 percent of the insurer's admitted assets.

*e.* Nothing contained in this rule shall prohibit a domestic insurer from acquiring an obligation as a result of a restructuring of a medium or lower grade obligation already held.

*f.* Nothing contained in this rule shall require a domestic insurer to sell or otherwise dispose of any obligation legally acquired prior to January 29, 1991.

*g.* The board of directors of any domestic insurance company which acquires or invests, directly or indirectly, more than 2 percent of its admitted assets in medium grade and lower grade obligations of any institution shall adopt a written plan for the making of such investments. The plan, in addition

to guidelines with respect to the quality of the issues invested in, shall contain diversification standards including, but not limited to, standards for issuer, industry, duration, liquidity and geographic location.

This rule is intended to implement Iowa Code sections 511.8 and 515.35.

**191—5.33(510) Credit for reinsurance.**

**5.33(1) Purpose.** The purpose of this rule is to set forth the procedural requirements which the insurance commissioner deems necessary to carry out the provisions of Iowa Code sections 521B.1 to 521B.5. The actions and information required by this rule are hereby declared to be necessary and appropriate to the public interest and for the protection of the ceding insurers in this state.

**5.33(2) Applicability.** This rule shall have no applicability to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

**5.33(3) Reinsurer licensed in this state.** The commissioner shall allow credit for reinsurance ceded by a domestic insurer to assuming insurers which were licensed in this state as of the date of the ceding insurer's statutory financial statement.

**5.33(4) Accredited reinsurers.**

*a.* The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this state as of the date of the ceding insurer's statutory financial statement. An accredited reinsurer is one which:

(1) Files a properly executed Form AR-1<sup>1</sup> as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records;

(2) Files with the commissioner a certified copy of a letter or a certificate of authority or of compliance as evidence that it is licensed to transact insurance or reinsurance in at least one state, or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(3) Files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement;

(4) Maintains a surplus as regards policyholders in an amount not less than \$20 million or obtains the affirmative approval of the commissioner upon a finding that the accredited reinsurer has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

*b.* If the commissioner determines that the assuming insurer has failed to meet or maintain any of these qualifications, the commissioner may upon written notice and hearing suspend or revoke the accreditation. A domestic ceding insurer shall not be allowed credit under this subrule if the assuming insurer's accreditation has been revoked by the commissioner or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the commissioner.

**5.33(5) Reinsurer domiciled and licensed in another state.**

*a.* The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which as of the date of the ceding insurer's statutory financial statement:

(1) Is domiciled and licensed in (or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed in) a state which employs standards regarding credit for reinsurance substantially similar to those applicable in this state;

(2) Maintains a surplus as regards policyholders in an amount not less than \$20 million;

(3) Files a properly executed Form AR-1<sup>1</sup> with the commissioner as evidence of its submission to this state's authority to examine its books and records.

*b.* The provisions of this subrule relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used herein, "substantially similar standards" means credit for reinsurance standards which the commissioner determines equal or exceed the standards of this state.

**5.33(6) *Reinsurers maintaining trust funds.***

*a.* The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement, maintains a trust fund in an amount prescribed below in a qualified United States financial institution, as determined by the commissioner, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interests. The assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund.

*b.* The following requirements apply to the following categories of assuming insurer:

(1) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States domiciled insurers, and in addition, the assuming insurer shall maintain a trustee surplus of not less than \$20 million, except as provided in subparagraph 5.33(6) "b"(4).

(2) The trust fund for a group of individual unincorporated underwriters shall consist of funds in trust in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trustee surplus of which \$100 million shall be held jointly for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the commissioner annual certifications by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter member of the group.

(3) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholder surplus of \$10 billion (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners) and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the assuming insurers' liabilities attributable to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trustee surplus of which \$100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group. The group shall file a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the commissioner annual certifications by the members' domiciliary regulators and their independent public accountants of the solvency of each member of the group.

(4) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than 30 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

*c.* The trust shall be established in a form approved by the commissioner. The trust instrument shall provide that:

(1) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States.

(2) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States policyholders and ceding insurers, their assigns and successors in trust.

(3) The trust shall be subject to examination as determined by the commissioner.

(4) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust.

(5) No later than February 28 of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(6) No amendment to the trust shall be effective unless reviewed and approved in advance by the commissioner.

**5.33(7) Certified reinsurers.**

a. The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this subrule. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with subrules 5.33(10), 5.33(11) and 5.33(12) of this rule and 2013 Iowa Acts, Senate File 182, sections 2(5) and 3. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

(1) Ratings/security.

Ratings	Security Required
Secure – 1	0%
Secure – 2	10%
Secure – 3	20%
Secure – 4	50%
Secure – 5	75%
Vulnerable – 6	100%

(2) Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

(3) The commissioner shall require the certified reinsurer to post 100 percent, for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.

(4) In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner. When determining what constitutes a catastrophic occurrence, the commissioner will consult with the NAIC and consider both natural and human events. The one-year deferral period is contingent upon the certified reinsurer's continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

1. Line 1: Fire
2. Line 2: Allied Lines
3. Line 3: Farmowners multiple peril
4. Line 4: Homeowners multiple peril
5. Line 5: Commercial multiple peril
6. Line 9: Inland Marine
7. Line 12: Earthquake
8. Line 21: Auto physical damage

(5) Credit for reinsurance under this subrule shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance

contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this subrule with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

(6) Nothing in this subrule shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this subrule.

*b.* Certification procedure.

(1) The commissioner shall post notice on the division's Web site promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least 30 days after posting the notice required by this subparagraph.

(2) The commissioner shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with paragraph 5.33(7) "a." The commissioner shall publish a list of all certified reinsurers and their ratings.

(3) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

1. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to paragraph 5.33(7) "c."

2. The assuming insurer must maintain capital and surplus, or their equivalents, of no less than \$250 million calculated in accordance with paragraph 5.33(7) "b"(4)"8." This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least \$250 million and a central fund containing a balance of at least \$250 million.

3. The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the commissioner in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

- Standard & Poor's;
- Moody's Investors Service;
- Fitch Ratings;
- A.M. Best Company; or
- Any other nationally recognized statistical rating organization.

4. The certified reinsurer must comply with any other requirements reasonably imposed by the commissioner.

(4) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

1. The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The commissioner shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. Failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification.

Ratings	Best	S&P	Moody's	Fitch
Secure – 1	A++	AAA	Aaa	AAA
Secure – 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure – 3	A	A+, A	A1, A2	A+, A
Secure – 4	A-	A-	A3	A-
Secure – 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable – 6	B, B-, C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

2. The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations.

3. For certified reinsurers domiciled in the United States, a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers).

4. For certified reinsurers not domiciled in the United States, a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers) (Forms CR-F and CR-S are available from the division).

5. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than 90 days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership.

6. Regulatory actions against the certified reinsurer.

7. The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in paragraph 5.33(7) "b"(4)"8."

8. For certified reinsurers not domiciled in the United States, audited financial statements (audited United States GAAP basis if available; audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a United States GAAP basis; or, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to United States GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the non-United States jurisdiction supervisor). Upon the initial application for certification, the commissioner will consider audited financial statements for the last three years filed with the certified reinsurer's non-United States jurisdiction supervisor.

9. The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding.

10. A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves United States ceding insurers. The commissioner shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement.

11. Any other information deemed relevant by the commissioner.

(5) Based on the analysis conducted under paragraph 5.33(7) "b"(4)"5" of a certified reinsurer's reputation for prompt payment of claims, the commissioner may make appropriate adjustments in the security that the certified reinsurer is required to post to protect its liabilities to United States ceding insurers, provided that the commissioner shall, at a minimum, increase the security that the certified reinsurer is required to post by one rating level under paragraph 5.33(7) "b"(4)"1" if the commissioner finds that:

1. More than 15 percent of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of 90 days or more which are not in dispute and which exceed \$100,000 for each ceding; or

2. The aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by 90 days or more exceeds \$50 million.

(6) The assuming insurer must submit a properly executed Form CR-1 as evidence of its submission to the jurisdiction of this state, appointment of the commissioner as an agent for service of process in this state, and agreement to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final United States judgment. The commissioner shall not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final United States judgments or arbitration awards.

(7) The certified reinsurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which is not otherwise public information subject to disclosure shall be exempted from disclosure under Iowa Code chapter 22 and shall be withheld from public disclosure. The applicable information filing requirements are as follows:

1. Notification within ten days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefor.

2. Annually, Form CR-F or CR-S, as applicable.

3. Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in paragraph 5.33(7) "b"(7)"4."

4. Annually, audited financial statements (audited United States GAAP basis if available; audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a United States GAAP basis; or, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to United States GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor). Upon the initial certification, audited financial statements for the last three years filed with the certified reinsurer's supervisor.

5. At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from United States domestic ceding insurers.

6. A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level.

7. Any other information that the commissioner may reasonably require.

(8) Change in rating or revocation of certification.

1. In the case of a downgrade by a rating agency or other disqualifying circumstance, the commissioner shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of paragraph 5.33(7) "b"(4)"1."

2. The commissioner shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this subrule, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the commissioner to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.

3. If the rating of a certified reinsurer is upgraded by the commissioner, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the commissioner shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the commissioner, the commissioner shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

4. Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with subrule 5.33(9) of this rule in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with subrule 5.33(6) of this rule, the commissioner may allow

additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

*c.* Qualified jurisdictions.

(1) If, upon conducting an evaluation under this subrule with respect to the reinsurance supervisory system of any non-United States assuming insurer, the commissioner determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the commissioner shall publish notice and evidence of such recognition in an appropriate manner. The commissioner may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

(2) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the reinsurance supervisory system of the non-United States jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. The commissioner shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the commissioner as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the commissioner, include but are not limited to the following:

1. The framework under which the assuming insurer is regulated.
2. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.
3. The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.
4. The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.
5. The domiciliary regulator's willingness to cooperate with United States regulators in general and the commissioner in particular.
6. The history of performance by assuming insurers in the domiciliary jurisdiction.
7. Any documented evidence of substantial problems with the enforcement of final United States judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final United States judgments or arbitration awards.
8. Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.
9. Any other matters deemed relevant by the commissioner.

(3) A list of qualified jurisdictions shall be published through the NAIC committee process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification with respect to the criteria provided under paragraphs 5.33(7) "c"(2)"1" to "9."

(4) United States jurisdictions that meet the requirements for accreditation under the NAIC Financial Standards and Accreditation Program shall be recognized as qualified jurisdictions.

*d.* Recognition of certification issued by an NAIC-accredited jurisdiction.

(1) If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form

CR-1 and such additional information as the commissioner requires. The assuming insurer shall be considered to be a certified reinsurer in this state.

(2) Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this state as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the commissioner of any change in its status or rating within ten days after receiving notice of the change.

(3) The commissioner may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with paragraph 5.33(7) "b"(7)"1."

(4) The commissioner may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the commissioner suspends or revokes the certified reinsurer's certification in accordance with paragraph 5.33(7) "b"(7)"2," the certified reinsurer's certification shall remain in good standing in this state for a period of three months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this state.

*e.* Mandatory funding clause. In addition to the clauses required under subrule 5.33(13) of this rule, reinsurance contracts entered into or renewed under this subrule shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this subrule for reinsurance ceded to the certified reinsurer.

*f.* The commissioner shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

**5.33(8) Credit for reinsurance required by law.** The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of this state, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this subrule, "jurisdiction" means any state, district or territory of the United States and any lawful national government.

**5.33(9) Reduction from liability for reinsurance ceded to an unauthorized assuming insurer.** The commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of this state in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution. This security may be in the form of any of the following:

*a.* Cash.

*b.* Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets.

*c.* Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as determined by the commissioner, effective no later than December 31 of the year for which filing is being made, and in the possession of, or in the trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

*d.* Any other form of security acceptable to the commissioner. An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer shall be allowed only when the requirements of this rule are met, as determined by the commissioner.

**5.33(10) Trust agreements qualified under subrule 5.33(9).**

*a.* *Definitions.* As used in this rule:

“*Beneficiary*” means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

“*Grantor*” means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

“*Obligations*” means:

1. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;
2. Reserves for reinsured losses reported and outstanding;
3. Reserves for reinsured losses incurred but not reported;
4. Reserves for allocated reinsured loss expenses and unearned premiums.

“*Qualified United States financial institution*” means an institution meeting the requirements of rule 191—32.4(508), except as permitted otherwise by the commissioner.

*b. Required conditions:*

(1) The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as determined by the commissioner.

(2) The trust agreement shall create a trust account into which assets shall be deposited.

(3) All assets in the trust account shall be held by the trustee at the trustee’s office in the United States, except that a bank may apply for the commissioner’s permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this subrule. If the commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in subparagraph 5.33(10)“*b*”(4) must also be presentable, as a matter of legal right, at the trustee’s principal office in the United States.

(4) The trust agreement shall provide that:

1. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

2. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

3. It is not subject to any conditions or qualifications outside of the trust agreement;

4. It shall not contain references to any other agreements or documents except as provided for under subparagraph 5.33(10)“*b*”(11).

(5) The trust agreement shall be established for the sole benefit of the beneficiary.

(6) The trust agreement shall require the trustee to:

1. Receive assets and hold all assets in a safe place;

2. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

3. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

4. Notify the grantor and the beneficiary, within ten days, of any deposits to or withdrawals from the trust account;

5. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary;

6. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(7) The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

(8) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.

(9) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(10) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.

(11) Notwithstanding other provisions of this rule, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may, notwithstanding any other conditions in this rule, provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:

1. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

2. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement;

3. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer, in any qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in subparagraph 5.33(10) "d"(1) as may remain executory after such withdrawal and for any period after the termination date.

(12) The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by subparagraph 5.33(10) "d"(1) so long as these required conditions are included in the trust agreement.

(13) Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by Iowa law or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed 5 percent of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this subparagraph must be included in the reinsurance agreement.

*c. Permitted conditions.*

(1) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice, and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(2) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock

or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(3) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in 5.33(10) "d"(1) "2."

(4) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(5) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

*d. Additional conditions applicable to reinsurance agreements.*

(1) A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

1. Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

2. Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the types permitted by the laws of this state for domestic insurers, or any combination of the above provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

3. Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

4. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent;

5. Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

- To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

- To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

- To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred (including losses incurred but not reported), loss adjustment expenses and unearned premium reserves;

- To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(2) The reinsurance agreement may also contain provisions that:

1. Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

- The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or
- After withdrawal and transfer, the market value of the trust account is not less than 102 percent of the required amount.

The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

2. Provide for:

• The return of any amount withdrawn in excess of the actual amounts required to comply with 5.33(10) "d"(1)"5," first three bulleted paragraphs, or in the case of 5.33(10) "d"(1)"5," fourth bulleted paragraph, any amounts that are subsequently determined not to be due; and

• Interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to 5.33(10) "d"(1)"5," third bulleted paragraph.

3. Permit the award by any arbitration panel or court of competent jurisdiction of:

- Interest at a rate different from that provided in 5.33(10) "d"(2)"2";
- Court of arbitration costs;
- Attorney's fees;
- Any other reasonable expenses.

(3) Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this division in compliance with the provision of this rule when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(4) Existing agreements. Any trust agreement or underlying reinsurance agreement in existence prior to January 1, 1992, will continue to be acceptable until January 1, 1993, at which time the agreements will have to be in full compliance with this rule for the trust agreement to be acceptable.

(5) The failure of any trust agreement to specifically identify the beneficiary as defined in paragraph 5.33(10) "a" shall not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the provisions of the laws of this state.

**5.33(11) Letters of credit qualified under subrule 5.33(9).**

*a.* The letter of credit must be clean, irrevocable and unconditional and issued or confirmed by a qualified United States financial institution. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in subparagraph 5.33(11) "i"(1). As used in this paragraph, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

*b.* The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

*c.* The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

*d.* The term of the letter of credit shall be for at least one year and shall contain an “evergreen clause” which prevents the expiration of the letter of credit without due notice from the issuer. The “evergreen clause” shall provide for a period of no less than 30 days’ notice prior to expiry date or nonrenewal.

*e.* The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

*f.* If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 500, or any successor publication, then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 17 of Publication 500 or any other successor publication, occur.

*g.* The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized pursuant to the organic laws of its chartering jurisdiction to issue letters of credit.

*h.* If the letter of credit is not issued by a qualified United States financial institution authorized to issue letters of credit, the following additional requirements shall be met:

(1) The issuing United States financial institution shall formally designate a qualified United States financial institution as its agent for the receipt and payment of the drafts;

(2) The “evergreen clause” shall provide for 30 days’ notice prior to expiry date for nonrenewal.

*i.* Reinsurance agreement provisions.

(1) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which:

1. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

2. Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

- To reimburse the ceding insurer for the assuming insurer’s share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

- To reimburse the ceding insurer for the assuming insurer’s share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

- To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer’s liabilities for policies ceded under the agreement (such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves);

- To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

3. All of the provisions required by paragraph 5.33(11) “i” should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(2) Nothing contained in this paragraph shall preclude the ceding insurer and assuming insurer from providing for:

1. An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to 5.33(11) “i”(1)“2,” third bulleted paragraph.

2. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the event 5.33(11) “i”(1)“2,” fourth bulleted paragraph, is applicable, any amounts that are subsequently determined not to be due.

(3) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, where it is customary practice to provide a letter of credit for a

specific purpose, then the reinsurance agreement may, in lieu of 5.33(11) “i”(1)“2,” require that the parties enter into a “Trust Agreement” which may be incorporated into the reinsurance agreement or be a separate document.

*j.* A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this division unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

**5.33(12) Other security.** A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

**5.33(13) Reinsurance contract.** Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of subrules 5.33(4), 5.33(5), 5.33(6), 5.33(7), 5.33(8), or 5.33(10) after the adoption of this rule unless the reinsurance agreement:

*a.* Includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to Iowa Code section 507C.32;

*b.* Includes a provision whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel; and

*c.* Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

**5.33(14) Contracts affected.** All new and renewal reinsurance transactions entered into after January 1, 2014, shall conform to the requirements of this rule if credit is to be given to the ceding insurer for such reinsurance.

**5.33(15) Severability.** If any provision of this rule, or the application of the provision to any person or circumstance, is held invalid, the remainder of the rule, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

This rule is intended to implement Iowa Code chapter 521B.  
[ARC 1111C, IAB 10/16/13, effective 1/1/14; ARC 1279C, IAB 1/8/14, effective 2/12/14]

<sup>1</sup> Available from Insurance Division

## **191—5.34(508) Actuarial opinion and memorandum.**

**5.34(1) Purpose and effective date.** The purpose of this rule is to prescribe:

*a.* Requirements for statements of actuarial opinion that are to be submitted in accordance with Iowa Code section 508.36 and for memoranda in support thereof;

*b.* Rules applicable to the appointment of an appointed actuary; and

*c.* Guidance as to the meaning of “adequacy of reserves.”

**5.34(2) Authority.** This rule is issued pursuant to the authority vested in the commissioner of insurance under Iowa Code section 508.36. This rule will take effect for annual statements for the year 2004.

**5.34(3) Scope.** This rule shall apply to all life insurance companies and fraternal benefit societies doing business in this state and to all life insurance companies and fraternal benefit societies which are authorized to reinsure life insurance, annuities or accident and health insurance business in this state.

This rule shall be applied in a manner that allows the appointed actuary to utilize the actuary’s professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the

commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

This rule shall be applicable to all annual statements filed with the office of the commissioner after January 1, 2004. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with subrule 5.34(6), and a memorandum in support thereof in accordance with subrule 5.34(7), shall be required each year.

**5.34(4) Definitions.** As used in this rule:

*"Actuarial opinion"* means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with subrule 5.34(6) and with applicable actuarial standards.

*"Actuarial Standards Board"* means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

*"Annual statement"* means that statement required by Iowa Code section 508.11 to be filed annually by the company with the office of the commissioner.

*"Appointed actuary"* means any individual who is appointed or retained in accordance with the requirements set forth in 5.34(5) "c" to provide the actuarial opinion and supporting memorandum as required by Iowa Code section 508.36.

*"Asset adequacy analysis"* means an analysis that meets the standards and other requirements referred to in 5.34(5) "d."

*"Commissioner"* means the insurance commissioner of this state.

*"Company"* means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this rule.

*"Qualified actuary"* means any individual who meets the requirements set forth in 5.34(5) "b."

**5.34(5) General requirements.**

*a. Submission of statement of actuarial opinion.*

(1) There is to be included on or attached to page 1 of the annual statement for each year beginning with the statement filed as of December 31, 2004, the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with 5.34(6).

(2) Upon written request by the company, the commissioner may grant an extension of the date for submission of the statement of actuarial opinion.

*b. Qualified actuary.* A "qualified actuary" is an individual who:

(1) Is a member in good standing of the American Academy of Actuaries;

(2) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(3) Is familiar with the valuation requirements applicable to life and health insurance companies;

(4) Has not been found by the commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing, to have:

1. Violated any provision of, or any obligation imposed by, the insurance code or other law in the course of dealing as a qualified actuary;

2. Been found guilty of fraudulent or dishonest practices;

3. Demonstrated incompetency, lack of cooperation, untrustworthiness to act as a qualified actuary;

4. Submitted to the commissioner during the past five years, pursuant to this rule, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this rule including standards set by the Actuarial Standards Board; or

5. Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(5) Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under 5.34(5) "b"(4).

*c. Appointed actuary.* An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by this rule, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The company shall give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements set forth in 5.34(5) "b." Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in 5.34(5) "b." If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

*d. Standards for asset adequacy analysis.* The asset adequacy analysis required by this rule shall:

(1) Conform to the standards of practice as promulgated from time to time by the Actuarial Standards Board and any additional standards under this rule, which standards are to form the basis of the statement of actuarial opinion in accordance with 5.34(6);

(2) Be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

*e. Liabilities to be covered.*

(1) Under the authority of Iowa Code section 508.36, the statement of actuarial opinion shall apply to all in-force business on the statement date, whether directly issued or assumed, regardless of when or where issued, e.g., reserves of Exhibits 8, 9, and 10, and claim liabilities in Exhibit 11, part 1, and equivalent items in the separate account statement or statements.

(2) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in Iowa Code section 508.36, the company shall establish the additional reserve.

(3) Additional reserves established under 5.34(5) "e"(2) and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

**5.34(6) Statement of actuarial opinion based on an asset adequacy analysis.**

*a. General description.* The statement of actuarial opinion submitted in accordance with this subrule shall consist of:

(1) A paragraph identifying the appointed actuary and the actuary's qualifications (see 5.34(6) "b"(1));

(2) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis (see 5.34(6) "b"(2)), and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see 5.34(6) "b"(3))), supported by a statement of each such expert in the form prescribed by 5.34(6) "e"; and

(4) An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see 5.34(6) "b"(6)).

(5) One or more additional paragraphs will be needed in individual company cases as follows:

1. If the appointed actuary considers it necessary to state a qualification of opinion;

2. If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

3. If the appointed actuary must disclose whether additional reserves of the prior opinion date are released as of this opinion date, and the extent of the release;

4. If the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

*b. Recommended language.* The following paragraphs shall be included in the statement of actuarial opinion in accordance with this subrule. Language is that which in typical circumstances should be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses the actuary's professional judgment. However, in any event, the opinion shall retain all pertinent aspects of the language provided in this subrule.

(1) The opening paragraph should generally indicate the appointed actuary's relationship to the company and qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

"I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the board of directors of said insurer to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

For a consulting actuary, the opening paragraph should include a statement such as:

"I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the board of directors of [name of company] to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20\_\_\_\_. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis."

Asset Adequacy Tested Amounts – Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b) (3)	Other Amount (4)	Total Amount (1)+(2)+(3) (4)
Exhibit 5					
A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					
D Accidental Death Benefit					
E Disability—Active					
F Disability—Disabled					
G Miscellaneous					
Total (Exhibit 5 Item 1, Page 3)					
Exhibit 6					
A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 6 Item 2, Page 3)					
Exhibit 7					
Premiums and Other Deposit Funds (Column 5, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					

Asset Adequacy Tested Amounts – Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b) (3)	Other Amount (4)	Total Amount (1)+(2)+(3) (4)
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities (Column 3, Line 14)					
Dividend Accumulations or Refunds (Column 4, Line 14)					
Total Exhibit 7 (Column 1, Line 14)					
Exhibit 8, Part 1					
1 Life (Page 3, Line 4.1)					
2 Health (Page 3, Line 4.2)					
Total Exhibit 8, Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)					
TOTAL RESERVES					
IMR (General Account, Page ____ Line ____)					
(Separate Accounts, Page ____ Line ____)					
AVR (Page ____ Line ____)		(c)			
Net Deferred and Uncollected Premium					

## Notes:

- (a) The additional actuarial reserves are the reserves established under subparagraph (2) of 5.34(5) “e.”
- (b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in paragraph 5.34(5) “d,” by means of symbols that should be defined in footnotes to the table.
- (c) Allocated amount of asset valuation reserve (AVR).

(3) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

“I have relied on [name], [title] for [e.g., ‘anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios’ or ‘certain critical aspects of the analysis performed in conjunction with forming my opinion’], as certified in the attached statement. I have reviewed the information relied upon for reasonableness.”

Such a statement of reliance on other experts should be accompanied by a statement by each of such experts in the form prescribed by 5.34(6) “e.”

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

“My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company’s current annual statement.”

(5) If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

“In forming my opinion on [specify types of reserves], I relied upon data prepared by [name and title of company officer certifying in-force records or other data] as certified in the attached statements.

I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."

The section shall be accompanied by a statement by each person relied upon in the form prescribed by 5.34(6)"e."

(6) The opinion paragraph shall include a statement such as:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

"1. Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

"2. Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

"3. Meet the requirements of the insurance law and rules of the state of [state of domicile]; and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

"4. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and

"5. Include provision for all actuarial reserves and related statement items which ought to be established.

"The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the commissioner, this language may be omitted for an opinion filed on behalf of a company doing business only in this state and in no other state.)

"The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

"The following material change(s) which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

"The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

\_\_\_\_\_  
Signature of Appointed Actuary

\_\_\_\_\_  
Address of Appointed Actuary

\_\_\_\_\_  
Telephone Number of Appointed Actuary

\_\_\_\_\_  
Date"

*c. Assumptions for new issues.* The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this subrule.

*d. Adverse opinion.* If the appointed actuary is unable to form an opinion, then the actuary shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified,

then the actuary shall issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

*e. Reliance on information furnished by other persons.* If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons upon whom the actuary is relying and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

*f. Alternate option.*

(1) Iowa Code section 508.36 gives the commissioner broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of subparagraph 5.34(6)“b”(6), item “3,” the commissioner may make one or more of the following additional approaches available to the opening actuary:

1. A statement that the reserves “meet the requirements of the insurance laws and regulations of the State of [state of domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile.” If the commissioner chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

2. A statement that the reserves “meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company’s request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the commissioner for approval of that request have been met.” If the commissioner chooses to allow this alternative, a formal written statement of such allowance shall be issued no later than March 31 of the year it is first effective. The statement shall remain valid until rescinded or modified by the commissioner. A rescission or modification of the statement shall be issued no later than March 31 of the year it is first effective. After that statement is issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year the opinion is to be filed. The request shall be deemed approved on October 1 of that year if the commissioner has not denied the request by that date.

3. A statement that the reserves “meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have submitted the required comparison as specified by this state.”

- If the commissioner chooses to allow this alternative, a formal written list of products (to be added to the table in 5.34(6)“f”(1)“3,” second bulleted paragraph) for which the required comparison shall be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

- If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under National Association of Insurance Commissioners codification standards adopted in rule 191—5.15(508,512B,514,514B,515,520). Gross nationwide reserves are the total reserves calculated for the total company in-force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall include at least the following:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

- The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative.

- If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

- The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(2) Notwithstanding 5.34(6)“f”(1), the commissioner may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within 60 days of the request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract an independent actuary at the company’s expense to prepare and file an opinion.

**5.34(7)** *Description of actuarial memorandum including an asset adequacy analysis and regulatory asset adequacy issues summary.*

a. *General.*

(1) In accordance with Iowa Code section 508.36, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of the opinion regarding the reserves. The memorandum shall be made available for examination by the commissioner upon request but shall be returned to the company after such examination and shall not be considered a record of the insurance division or subject to automatic filing with the commissioner.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of the actuary’s own memorandum, memoranda, prepared and signed by other actuaries who are qualified within the meaning of 5.34(5)“b” with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the commissioner requests a memorandum and no such memorandum exists or if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this rule, the commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company, and the work papers and documentation of the reviewing actuary shall be retained by the commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the commissioner pursuant to the statute governing this rule. The reviewing actuary shall not be an employee or a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this rule for the current year or the preceding three years.

(5) In accordance with Iowa Code section 508.36, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in 5.34(7)“c.” Companies submitting the regulatory asset adequacy issues summary shall submit the summary no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. Iowa foreign companies are not required to submit the regulatory asset adequacy issues summary annually; however, the summary shall be made available for examination by the commissioner

upon request. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

*b. Details of the memorandum section documenting asset adequacy analysis (5.34(6)).* When an actuarial opinion under 5.34(6) is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in 5.34(5) “d” and any additional standards under this rule. It shall specify:

- (1) For reserves:
  1. Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;
  2. Source of liability in force;
  3. Reserve method and basis;
  4. Investment reserves;
  5. Reinsurance arrangements;
  6. Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;
  7. Documentation of assumptions to test reserves for the following:
    - Lapse rates (both base and excess);
    - Interest crediting rate strategy;
    - Mortality;
    - Policyholder dividend strategy;
    - Competitor or market interest rate;
    - Annuitization rates;
    - Commissions and expenses; and
    - Morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

- (2) For assets:
  1. Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;
  2. Investment and disinvestment assumptions;
  3. Source of asset data;
  4. Asset valuation bases; and
  5. Documentation of assumptions made for:
    - Default costs;
    - Bond call function;
    - Mortgage prepayment function;
    - Determining market value for assets sold due to disinvestment strategy; and
    - Determining yield on assets acquired through the investment strategy.

The documentation of assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

- (3) For the analysis basis:
  1. Methodology;
  2. Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;
  3. Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of “materiality” that was used in determining how vigorously to analyze different blocks of business);
  4. Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under “moderately adverse conditions” or other conditions as specified in relevant actuarial standards of practice); and

5. Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis.

(4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis.

(5) Conclusion(s).

*c. Details of the regulatory asset adequacy issues summary.*

(1) The regulatory asset adequacy issues summary shall include:

1. Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserves as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in-force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force;

2. The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different from the assumptions used in the previous asset adequacy analysis;

3. The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

4. Comments on any interim results that may be of significant concern to the appointed actuary, for example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods;

5. The methods used by the actuary to recognize the impact of reinsurance on the company cash flows, including both assets and liabilities, under each of the scenarios tested; and

6. Whether the actuary has been satisfied that all options, whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equitylike features in any investments have been appropriately considered in the asset adequacy analysis.

(2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

*d. Conformity to standards of practice.* The memorandum shall include the following statement: "Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate standards of practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

*e. Use of assets supporting the interest maintenance reserve and the asset valuation reserve.* An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

The amount of assets used for the AVR shall be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets must be disclosed in the memorandum.

*f. Documentation.* The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

This rule is intended to implement Iowa Code section 508.36.

[ARC 9184B, IAB 11/3/10, effective 12/8/10]

**191—5.35 to 5.39** Reserved.

**191—5.40(515) Premium tax.** The fact that the companies choose to call a stipulated amount a “policy fee” and do not include it under the term of “premium” would not have the effect of exempting this income from taxation. It is most assuredly a part of the premium or income received from policyholders for business done in Iowa and thus subject to taxation.

**191—5.41(508) Tax on gross premiums—life companies.** In determining the gross amount of premiums to be taxed hereunder, there shall be excluded:

1. All premiums returned to policyholders or annuitants during the preceding calendar year, except cash surrender values.
2. All dividends that, during said year, have been paid in cash or applied in reduction of premiums or left to accumulate to the credit of policyholders or annuitants.

**191—5.42(432) Cash refund of premium tax.** A cash refund of premium tax may be made to an insurance company that has paid a premium tax payment or prepayment and demonstrates an inability to recoup the funds paid via a credit, provided that the insurance division determines that a refund is appropriate. A claim for refund is a formal request made by the insurance company or its successor in interest to the insurance division for repayment of premium tax prepayments that were paid with the insurance company’s previously filed tax return. The claim for refund shall not be filed with a premium tax prepayment, annual tax payment, or with other documents or forms submitted to the division.

**5.42(1) Eligibility criteria.** Upon the written application of an insurance company or its successor in interest, the insurance division shall authorize the department of revenue to make a cash refund to an insurer if:

- a. The insurance company is subject to an order of liquidation or equivalent order issued by a court of competent jurisdiction; or
- b. The insurance company has not written any business in the state of Iowa for five years; or
- c. The insurance company’s certificate of authority is voluntarily or involuntarily surrendered or terminated; upon application for a refund, the company shall be prohibited from applying for readmission in Iowa for at least five years; and
- d. The insurance company has no insurer within its holding company which could utilize the credit.

**5.42(2) Application procedure.** An insurance company may file a claim for a cash refund with the insurance division by stating in detail the reasons and facts and including supporting documents with the claim for a cash refund. These documents shall include but not be limited to:

- a. A written request applying for a cash refund and identifying the address where the cash refund should be mailed;
- b. A copy of the tax return from which the premium tax credit originated;
- c. A copy of the liquidation order or other documentation demonstrating that the insurance company’s certificate of authority has been surrendered and that the company is prohibited from applying for admission in Iowa for at least five years; and
- d. A certification from the chief executive officer stating that the company has no plans for writing business in the state of Iowa and agrees to notify the insurance division before writing any business in this state if the claim for refund is made pursuant to 5.42(1) “b.”

**5.42(3) Appeals.** If the claim for refund is denied and the applicant wishes to appeal the denial, the insurance division will consider an appeal to be timely if filed not later than 30 days following the date of denial.

**5.42(4) Statute of limitations.** Upon meeting the eligibility criteria outlined in 5.42(1), an insurance company has up to five years to file an application for a refund. A refund will not be authorized if an application is not made within this time frame.

This rule is intended to implement Iowa Code section 432.1(6).

**191—5.43(510) Managing general agents.**

**5.43(1)** The requirement that a domestic insurer submit its contracts with managing general agents for approval of the commissioner of insurance set forth in Iowa Code section 510.2 remains in effect after July 1, 1991.

**5.43(2)** A managing general agent shall at all times maintain a surety bond in the amount of \$50,000 issued by an insurer licensed to transact business in this state for the benefit of each domestic insurer with which the managing general agent has contracted.

**5.43(3)** A managing general agent shall maintain an errors and omissions policy in the face amount of \$250,000.

**5.43(4)** A third-party administrator subject to Iowa Code chapter 510 shall not be deemed to be a managing general agent.

**5.43(5)** The amount of claims in excess of which a person is authorized to adjust or pay for purposes of the definition of “managing general agent” in Iowa Code section 510.2A(4) “a”(3) “a” is \$15,000 per claim.

## DISCLOSURE OF MORTGAGE LOAN APPLICATIONS

**191—5.44 to 5.49** Reserved.

**191—5.50(535A) Purpose.** These rules are adopted for the purpose of enforcing Iowa Code sections 535A.2 and 535A.4.

**191—5.51(535A) Definitions.**

**5.51(1)** “*Reporting financial institution*” means a person which holds a certificate of authority to act as an insurer pursuant to any provision of Title XX, Iowa Code, if the person:

- a. At the beginning of a reporting period possessed assets in excess of \$10 million; and
- b. During a reporting period received applications for mortgage loans on residential property situated in any Iowa city with a population in excess of 50,000, as determined in the most recent census, or in any standard metropolitan statistical area.

**5.51(2)** “*Application*” means an oral or written request for an extension of credit that is made in accordance with procedures established by a financial institution for the type of credit requested.

**5.51(3)** “*Reporting period*” means the calendar year beginning January 1, 1979, and each calendar year thereafter.

**5.51(4)** “*Mortgage loan*” means a mortgage loan as defined in Iowa Code section 535A.1, which is secured by a primary or secondary lien against residential property located in this state.

**5.51(5)** “*Residential property*” means real property used or to be used for residential purposes, including single family homes, dwellings for from two to four families and individual units of condominiums and townhouses.

**5.51(6)** “*Residential mortgage loan*” means a mortgage loan other than a construction loan, a home improvement loan or a rehabilitation loan.

**5.51(7)** “*Construction loan*” means a loan for a maximum of two years for the purpose of construction.

**5.51(8)** “*Interest rate*” means the rate stated on the indenture.

**5.51(9)** “*Standard metropolitan statistical area*” means an area located wholly or partly in the state of Iowa which is designated a standard metropolitan statistical area by the United States Department of Commerce.

**191—5.52(535A) Filing of reports.**

**5.52(1)** Every reporting financial institution shall file the reports required by rule 191—5.53(535A) with the director of the Iowa housing finance authority, Des Moines, Iowa 50319, and with the commissioner of insurance, Des Moines, Iowa 50319, on or before January 15, 1980, and each year thereafter by January 15, and shall maintain a copy of each report at the office where its principal financial records are maintained for a period of five years after it is filed.

**5.52(2)** Reporting financial institutions shall file a report which complies with the Federal Home Mortgage Act of 1975, 12 U.S.C. 2801 to 2809, and regulations promulgated under that Act. Reporting financial institutions shall also report additional information required by rule 191—5.54(535A).

**191—5.53(535A) Form and content of reports.**

**5.53(1)** Reports required by rule 191—5.53(535A) shall be filed on Disclosure Form A<sup>1</sup> or a form similar thereto.

**5.53(2)** Financial institutions may submit computer printouts in lieu of the specimen form if the computer printouts contain the same information in the same sequence as on the specimen form.

**5.53(3)** Every report filed shall disclose the following information:

*a.* Name and address of the reporting financial institution.  
*b.* Name, address and telephone number of the officer designated by the reporting financial institution to file the report.

*c.* Reporting period.

*d.* The principal amount of a loan shall be disclosed with respect to construction loan applications, home improvement loan applications, total mortgage loan applications, and residential mortgage loan applications, and the requested amount shall be disclosed with respect to construction loan applications not approved, home improvement loan applications not approved, total mortgage loan applications not approved and residential mortgage loan applications not approved. The principal and requested amount disclosures required above shall be reported separately for each census tract or zip code area.

**5.53(4)** Each report shall also indicate the number of persons requesting to examine the disclosure report for the previous reporting period.

<sup>1</sup> Form omitted under Iowa Code section 17A.6(3). They are available upon request from the agency.

**191—5.54(535A) Additional information required.**

**5.54(1)** Reporting financial institutions shall file with the commissioner of insurance on or before March 15 of each year Disclosure Form B or a form similar thereto the following additional information with respect to loans for the purchase of residential property made during the preceding year:

*a.* The number of loans approved at each of the following percentages of the appraised value of the property used as security for the loan:

- (1) Less than 60 percent
- (2) 60 percent to 69 percent
- (3) 70 percent to 79 percent
- (4) 80 percent to 89 percent
- (5) 90 percent or more

*b.* The number of loans approved for each of the following amortization periods:

- (1) Less than 10 years
- (2) 10 to 14 years
- (3) 15 to 19 years
- (4) 20 to 24 years
- (5) 25 to 29 years
- (6) 30 or more

*c.* The number of loans made at each interest rate charged.

**5.54(2)** Reporting financial institutions are not required to file the additional information required by subrule 5.54(1) for any loan guaranteed in whole or part under any program of the United States or any of its agencies or instrumentalities, if:

*a.* The reporting financial institution made a written loan commitment for the loan at the maximum rate of interest permitted under the program at the time of the commitment, and

*b.* The amortization period for a loan is the maximum period permitted under the program or a shorter period established in response to a request initiated solely by the borrower, and

c. The loan is made at the maximum percentage of appraised value of the property permitted under the program or for the total amount which the borrower desired to borrow, and

d. The reporting financial institution files with the commissioner of insurance on or before March 15 of each year its verified statement, signed by an officer of the reporting financial institution, that it has made loans under such a program and that it has filed the report required by rule 5.54(2) for each such loan not exempted by this rule.

**191—5.55(535A) Written complaints.** Any person who has reason to believe that a financial institution has failed to comply with the provisions of Iowa Code chapter 535A or these rules may file a written complaint with the insurance division, Des Moines, Iowa 50319, or bring an action in the district court in accordance with Iowa Code chapter 535A.

These rules are intended to implement Iowa Code sections 535A.2 and 535A.4.

**191—5.56 to 5.89** Reserved.

**191—5.90(145) Implementation of health data commission directives.** Rescinded IAB 11/15/00, effective 12/20/00.

[Filed 8/1/63, amended 11/21/63, 1/13/71]

[Filed emergency 5/24/76, Notice 4/19/76—published 6/14/76, effective 5/24/76]

[Filed emergency 2/13/79—published 3/7/79, effective 2/13/79]

[Filed emergency after Notice 7/20/79, Notice 3/7/79—published 8/8/79, effective 7/31/79]

[Filed 4/4/84, Notice 2/29/84—published 4/25/84, effective 5/30/84]

[Filed 4/3/85, Notice 2/27/85—published 4/24/85, effective 5/29/85]

[Filed 10/3/86, Notice 8/27/86—published 10/22/86, effective 11/26/86]

[Editorially transferred from [510] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]

[Filed 2/5/88, Notice 12/30/87—published 2/24/88, effective 3/30/88]

[Filed 12/9/88, Notice 10/5/88—published 12/28/88, effective 2/1/89]

[Filed 7/21/89, Notice 5/31/89—published 8/9/89, effective 9/13/89]

[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 5/9/90]

[Filed 1/4/91, Notice 11/28/90—published 1/23/91, effective 2/27/91]

[Filed 4/12/91, Notice 3/6/91—published 5/1/91, effective 6/5/91]

[Filed emergency 6/21/91—published 7/10/91, effective 6/21/91]

[Filed 7/3/91, Notice 5/29/91—published 7/24/91, effective 8/28/91]<sup>◇</sup>

[Filed 8/15/91, Notice 7/10/91—published 9/4/91, effective 10/9/91]

[Filed 12/6/91, Notice 10/30/91—published 12/25/91, effective 1/29/92]<sup>◇</sup>

[Filed emergency 11/6/92—published 11/25/92, effective 11/6/92]

[Filed 8/13/93, Notice 7/7/93—published 9/1/93, effective 10/6/93]

[Filed 10/20/95, Notice 9/13/95—published 11/8/95, effective 1/1/96]

[Filed 3/5/99, Notice 11/4/98—published 3/24/99, effective 4/28/99]

[Filed 10/27/00, Notice 9/20/00—published 11/15/00, effective 12/20/00]

[Filed emergency 12/14/00 after Notice 8/23/00—published 1/10/01, effective 1/1/01]

[Filed emergency 12/4/03 after Notice 10/1/03—published 12/24/03, effective 1/1/04]<sup>◇</sup>

[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]

[Filed 7/17/07, Notice 3/14/07—published 8/15/07, effective 9/19/07]

[Filed ARC 9184B (Notice ARC 9069B, IAB 9/8/10), IAB 11/3/10, effective 12/8/10]

[Filed ARC 9228B (Notice ARC 9079B, IAB 9/22/10), IAB 11/17/10, effective 12/22/10]

[Filed ARC 1111C (Notice ARC 0960C, IAB 8/21/13), IAB 10/16/13, effective 1/1/14]

[Filed ARC 1279C (Notice ARC 1178C, IAB 11/13/13), IAB 1/8/14, effective 2/12/14]

<sup>◇</sup> Two or more ARCs



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under the “umbrella” of Commerce Department[181] by 1986 Iowa Acts, Senate File 2175, section 740.

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CHAPTER 23  
ANNUAL REPORT

[Prior to 10/8/86, Commerce Commission[250]]

**199—23.1(476) General information.**

**23.1(1)** Every public utility is required to keep and render its books, accounts, papers, and records accurately and faithfully in the manner and form prescribed by the board and to comply with all directions of the board relating to such books, accounts, papers, and records.

**23.1(2)** Each public utility subject to Iowa Code chapter 476 shall file with this board, on or before April 1 of each year, an annual report as described in this chapter and covering operations during the immediately preceding calendar year. Pursuant to Iowa Code chapter 476, this information will be used to apportion the costs of the utilities division. If a utility ceases operations through merger or sale of its plant during the calendar year, each utility involved in the transaction shall separately file, within 90 days after the merger or sale, an annual report covering the portion of the calendar year operations to the date of sale or merger.

**23.1(3)** All pages of the report must be completed and submitted to the board. The words “none” or “not applicable” may be used to complete a schedule when they accurately and fully state the facts. The board shall be notified of the nature, amount, and purpose of any accounts used in addition to those prescribed in utilities division 199—Chapter 16. A copy shall be retained in the respondent’s file. All reports are to be prepared for and certified to the Iowa utilities board.

**23.1(4)** Annual report requirements specified in “Regulations Governing Service Supplied by Gas, Electric, Telephone, or Water Utilities,” utilities division, 199—Chapters 19, 20, 21, and 22, shall be included with the annual reports set forth in the following paragraphs. The reporting utility should use its own format in preparing such reports.

**199—23.2(476) Annual report requirements—rate-regulated utilities.** Two copies each of the following report forms must be completed and filed with the board.

**23.2(1) Electric utilities.**

*a.* Major electric utilities—Form IE-1, Annual Report—Rate-Regulated electric utilities (including FERC Annual Report Form No. 1). A “major” electric utility is defined as a utility that had, in each of the last three consecutive years, sales or transmission service that exceeded any one or more of the following: (1) 1 million megawatt hours of total sales; (2) 100 megawatt hours of sales for resale; (3) 500 megawatt hours of power exchanges delivered; or (4) 500 megawatt hours of wheeling for others (deliveries plus losses). Title 18 CFR Part 101, General Instructions 1.A.(1).

*b.* Nonmajor electric utilities—Form IE-1, Annual Report—Rate-Regulated electric utilities (including FERC Annual Report Form No. 1F). A “nonmajor” electric utility is defined as a utility that is not classified as major and had total sales in each of the last three consecutive years of 10,000 megawatt hours or more. Title 18 CFR Part 101, General Instructions 1.A.(2).

**23.2(2) Gas utilities.**

*a.* Major gas utilities—Form IG-1, Annual Report—Rate-Regulated gas utilities (including FERC Annual Report Form No. 2). A “major” gas utility is defined as a gas utility whose combined gas sold for resale and gas transported or stored for a fee exceeds 50 million Mcf at 14.73 psi (60° F) in each of the three previous calendar years. Title 18 CFR Part 201, General Instructions 1.

*b.* Nonmajor gas utilities—Form IG-1, Annual Report—Rate-Regulated gas utilities (including FERC Annual Report Form No. 2A). A “nonmajor” gas utility is defined as a utility (1) that is not classified as a major gas utility and (2) that had total gas sales volume transactions exceeding 200,000 Mcf at 14.73 psi (60° F) in each of the three previous calendar years. Title 18 CFR Part 201, General Instructions 1.

**23.2(3) Telegraph utilities.** Form RTG-1, Annual Report—Rate-Regulated Telegraph Utilities (including FCC Annual Report Form—R & O).

**23.2(4) Telephone utilities.** Form TR-1, Telephone Annual Report to the Utilities Board and Department of Revenue, State of Iowa (including FCC Annual Report Form M).

**23.2(5)** Water utilities.

- a. Class A & B—Form WA-1, Annual Report—Rate-Regulated Water Utilities.
- b. Class C & D—Form WD-1, Annual Report—Rate-Regulated Water Utilities.

**23.2(6)** Reports by rate-regulated utilities which have multistate operations shall provide information concerning their Iowa operations on the schedules listed below. Such schedules shall be prepared using the same format used in reporting total company data and shall be clearly labeled “Iowa Operations” at the top of each schedule. It shall include:

- a. Summary of utility plant and accumulated depreciation and amortization reserves.
- b. Plant in service by primary account.
- c. Materials and supplies.
- d. Contributions in aid of construction.
- e. Accumulated deferred income taxes.
- f. Accumulated investment credit.
- g. Statement of income for the year.
- h. Operating revenues.
- i. Operating and maintenance expenses.
- j. Taxes charged during year.

Statements shall be included setting forth the method or basis used in making allocations between states.

**23.2(7)** Cooperative Electric Utilities Corporations or Associations—Form EC-1, Annual Report—Cooperative Electric Plant and Operations.

**23.2(8)** The respondent shall file as part of its annual report filed with the board (a) a list (by title, author, and date) of any financial, statistical, technical or operational reviews or reports that a company may prepare for distribution to stockholders, bondholders, utility organizations or associations or other interested parties and (b) a list (by form number and title) of all financial, statistical, technical and operational review-related documents filed with an agency of the federal government.

**23.2(9)** In addition to the above-mentioned reports, the respondent shall file with the board, immediately upon publication, two copies of any financial or statistical reports that a company may prepare for distribution to stockholders, bondholders or any other interested parties.

This rule is intended to implement Iowa Code section 476.31.

**199—23.3(476)** **Annual report requirements—non-rate-regulated utilities.** One copy of each of the following report forms must be completed and filed with the board.

**23.3(1)** *Municipally owned electric.* Form ME-1, Annual Report—Municipal Electric Plant and Operations.

**23.3(2)** *Municipally owned gas utilities.* Form MG-1, Annual Report—Municipal Gas, Plant and Operations.

**23.3(3)** *Non-rate-regulated telephone utilities.* Form TR-1, Telephone Annual Report to the Utilities Board and Department of Revenue, State of Iowa.

**199—23.4(476,476A)** Renumbered as subrule 20.13(3), effective 10/31/84.

These rules are intended to implement Iowa Code sections 476.2, 476.9, 476.10, 476.22, 476.31, and 546.7.

[Filed 12/12/67]

[Filed 9/30/77, Notice 6/29/77—published 10/19/77, effective 11/23/77]

[Filed 4/11/83, Notice 1/19/83—published 4/27/83, effective 6/1/83]

[Filed 5/20/83, Notice 4/13/83—published 6/8/83, effective 7/13/83]

[Filed 9/10/84, Notice 2/15/84—published 9/26/84, effective 10/31/84]

[Filed emergency 9/18/86—published 10/8/86, effective 9/18/86]

[Filed 3/16/90, Notice 11/29/89—published 4/4/90, effective 5/9/90]

[Filed 4/14/00, Notice 2/23/00—published 5/3/00, effective 6/7/00]

[Filed 6/6/03, Notice 12/25/02—published 6/25/03, effective 7/30/03]

[Editorial change: IAC Supplement 1/8/14]



CHAPTER 25  
IOWA ELECTRICAL SAFETY CODE  
[Prior to 10/8/86, Commerce Commission[250]]

**199—25.1(476,476A,478) General information.**

**25.1(1) Authority.** The standards relating to electric and communication facilities in this chapter are prescribed by the Iowa utilities board pursuant to Iowa Code sections 476.1, 476.1B, 476.2, 476A.12, 478.19, and 478.20.

**25.1(2) Purpose.** The purpose of this chapter is to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities. The rules apply to electric and communication utility facilities located in the state of Iowa and shall supersede all conflicting rules of any such utility. This rule shall in no way relieve any utility from any of its duties under the laws of this state.

**25.1(3) Definition of utility.** For the purpose of this chapter, a utility is any owner or operator of electric or communications facilities subject to the safety jurisdiction of the board.  
[ARC 9501B, IAB 5/18/11, effective 6/22/11]

**199—25.2(476,476A,478) Iowa electrical safety code defined.** The standard minimum requirements for the installation and maintenance of electric substations, generating stations, and overhead and underground electric supply or communications lines adopted below, collectively constitute the “Iowa Electrical Safety Code.”

**25.2(1) National Electrical Safety Code.** The American National Standards Institute (ANSI) C2-2007 “National Electrical Safety Code” (NESC) as ultimately conformed to the ANSI-approved draft by correction of publishing errors through issuance of printed corrections is adopted as part of the Iowa electrical safety code, except Part 4, “Rules for Operation of Electric Supply and Communications Lines and Equipment,” which is not adopted by the board.

**25.2(2) Modifications and qualifications to ANSI C2.** The standards set forth in ANSI C2 are modified or qualified as follows:

*a.* Introduction to the National Electrical Safety Code.

(1) The following paragraph replaces NESC 011B: “The National Electrical Safety Code (NESC) covers utility facilities and functions from the point of generation by the utility, or delivery from another entity, of electricity or communications signals through the utility system to the point of delivery to a customer’s facilities.”

(2) NESC 013A2 is modified to read as follows: “Types of construction and methods of installation other than those specified in the rules may be used experimentally to obtain information, if done where:

1. Qualified supervision is provided,
2. Equivalent safety is provided,
3. On joint-use facilities, all affected parties agree, and
4. Prior approval is obtained from the Iowa utilities board.”

*b.* Minimum clearances.

(1) In any instance where minimum clearances are provided in Iowa Code chapter 478 which are greater than otherwise required by these rules, the statutory clearances shall prevail.

(2) The following clearances shall apply to all lines regardless of date of construction: NESC 232, vertical clearances for “Water areas not suitable for sailboating or where sailboating is prohibited,” “Water areas suitable for sailboating . . . ,” and “Established boat ramps and associated rigging areas . . . ”; and NESC 234E, “Clearance of Wires, Conductors, Cables or Unguarded Rigid Live Parts Installed Over or Near Swimming Areas With No Wind Displacement.”

(3) Table 232-1, Footnote 21, is changed to read: “Where the U.S. Army Corps of Engineers or the state, or a surrogate thereof, issues a crossing permit, the clearances of that permit shall govern if equal to or greater than those required herein. Where the permit clearances are less than those required herein and water surface use restrictions on vessel heights are enforced, the permit clearances may be used.”

(4) Except for clearances near grain bins, for measurements made under field conditions, the board will consider compliance with the overhead vertical line clearance requirements of Subsection 232 and Table 232-1 of the 1987 NESC indicative of compliance with the 1990 through 2007 editions of the NESC. (For an explanation of the differences between 1987 and subsequent code edition clearances, see Appendix A of the 1990 through 2007 editions of the NESC.)

c. Reserved.

d. Rule 217C.1 is changed to read:

“The ground end of anchor guys exposed to pedestrian or vehicle traffic shall be provided with a substantial marker not less than eight feet long. The guy marker shall be of a conspicuous color such as yellow, orange, or red. Green, white, gray or galvanized steel colors are not reliably conspicuous against plant growth, snow, or other surroundings. Noncomplying guy markers shall be replaced as part of the utility’s inspection and maintenance plan.”

e. There is added to Rule 381G:

(3) Pad-mounted and other aboveground equipment not located within a fenced or otherwise protected area shall have affixed to its outside access door or cover a prominent “Warning” or other appropriate sign of highly visible color, warning of hazardous voltage and including the name of the utility. This rule shall apply to all signs placed or replaced after June 18, 2003.

f. There is added to the first paragraph of Rule 110.A.1, after the sentence stating, “Entrances not under observation of an authorized attendant shall be kept locked,” the following sentences:

Entrances may be unlocked while authorized personnel are inside. However, if unlocked, the entrance gate must be fully closed, and must also be latched or fastened if there is a gate-latching mechanism.

g. Lines crossing railroad tracks shall comply with the additional requirements of 199 IAC 42.6(476), “Engineering standards for electric and communications lines.”

**25.2(3) Grain bins.**

a. Electric utilities shall conduct annual public information campaigns to inform farmers, farm lenders, grain bin merchants, and city and county zoning officials of the hazards of and standards for construction of grain bins near power lines.

b. An electric utility may refuse to provide electric service to any grain bin built near an existing electric line which does not provide the clearances required by the American National Standards Institute (ANSI)C2-2007 “National Electrical Safety Code,” Rule 234F. This paragraph “b” shall apply only to grain bins loaded by portable augers, conveyors or elevators and built after September 9, 1992, or to grain bins loaded by permanently installed augers, conveyors, or elevator systems installed after December 24, 1997.

**25.2(4) General rules.**

a. *Joint-use construction.* Where it is mutually agreeable between an electric utility and a communication or cable television company, communication circuits or cables may be buried in the same trench or attached to the same supporting structure, provided this joint use is permitted by, and is constructed in compliance with, the Iowa electrical safety code.

b. *Lines.* In order to limit the residual currents and voltages arising from line unbalances, the resistance, inductance, capacitance and leakage conductance of each phase conductor of an electric supply circuit in any section shall be as nearly equal as practical to the corresponding quantities in the other phase conductors in the same section.

The ampacity of a multigrounded neutral conductor of an electric supply circuit shall be adequate for the load which it is required to carry. The ampacity of a multigrounded neutral conductor of an electric supply circuit shall not be less than 60 percent of that of any phase conductor with which it is associated, except for three phase four wire wye circuits where it shall have ampacity not less than 50 percent of that of any associated phase conductor. In no case shall the resistance of a multigrounded neutral conductor exceed 3.6 ohms per mile. (This does not modify the mechanical strength requirements for conductors.) A multigrounded conductor installed and utilized primarily for lightning shielding of the associated phase conductors need not comply with the above percentage ampacity requirements for neutral conductors.

Where the neutral conductor of the electric supply circuit is not multigrounded or in an inductive exposure involving communication or signal circuits and equipment where the controlling frequencies are 360 Hertz or lower, any neutral conductor shall have the same ampacity as the phase conductors with which it is associated.

**25.2(5) Other references adopted.**

*a.* The “National Electrical Code,” ANSI/NFPA 70-2008, is adopted as a standard of accepted good practice for customer-owned electrical facilities beyond the utility point of delivery, except for installations subject to the provisions of the state fire marshal standards in 661 IAC 504.1(103).

*b.* “The Lineman’s and Cableman’s Handbook,” Eleventh Edition; Shoemaker, Thomas M. and Mack, James E.; New York, McGraw-Hill Book Co., is adopted as a recommended guideline to implement the “National Electrical Safety Code” or “National Electrical Code,” and for developing the inspection and maintenance plans required by 199 IAC 25.3(476,478).  
[ARC 7962B, IAB 7/15/09, effective 8/19/09; ARC 9501B, IAB 5/18/11, effective 6/22/11]

**199—25.3(476,478) Inspection and maintenance plans.**

**25.3(1) Filing of plan.** Each electric utility shall adopt and file with the board a written plan for inspecting and maintaining its electric supply lines and substations (excluding generating stations) in order to determine the necessity for replacement, maintenance, and repair, and for tree trimming or other vegetation management. If the plan is amended or altered, revised copies of the appropriate plan pages shall be filed.

**25.3(2) Annual report.** Each utility shall include as part of its annual report to the board, as required by 199—Chapter 23, certification of compliance with each area of the inspection plan or a detailed statement on areas of noncompliance.

**25.3(3) Contents of plan.** The inspection plan shall include the following elements:

*a. General.* A listing of all counties or parts of counties in which the utility has electric supply lines in Iowa. If the utility has district or regional offices responsible for implementation of a portion of the plan, the addresses of those offices and a description of the territory for which they are responsible shall also be included.

*b. Inspection of lines, poles, and substations.*

(1) Inspection schedules. The plan shall contain a schedule for the periodic inspection of the various units of the utility’s electric plant. The period between inspections shall be based on accepted good practice in the industry, but for lines and substations shall not exceed ten years for any given line or piece of equipment. Lines operated at 34.5 kV or above shall be inspected at least annually for damage and to determine the condition of the overhead line insulators.

(2) Inspection coverage. The plan shall provide for the inspection of all supply line and substation units within the adopted inspection periods and shall include a complete listing of all categories of items to be checked during an inspection.

(3) Conduct of inspections. Inspections shall be conducted in a manner conducive to the identification of safety, maintenance, and reliability concerns or needs.

(4) Instructions to inspectors. Copies of instructions or guide materials used by utility inspectors in determining whether a facility is in acceptable condition or in need of corrective action or further investigation.

*c. Tree trimming or vegetation management plan.*

(1) Schedule. The plan shall contain a schedule for periodic tree trimming or other measures to control vegetation growth under or along the various units of the utility’s electric plant. The period between inspections shall be based on accepted good practice in the industry and may vary depending on the nature of the vegetation at different locations.

(2) Procedures. The plan shall include written procedures for vegetation management. The procedures shall promote the safety and reliability of electric lines and facilities. Where tree trimming is employed, practices shall be adopted that will protect the health of the tree and reduce undesirable regrowth patterns.

*d. Pole inspections.* Pole inspections shall periodically include an examination of the poles that includes tests in addition to visual inspection in appropriate circumstances. These additional tests may include sounding, boring, groundline exposure, and, if applicable, pole treatment.

**25.3(4) Records.** Each utility shall keep sufficient records to demonstrate compliance with its inspection and vegetation management plans. For each inspection unit, the records of line and substation inspections and pole inspections shall include the inspection date(s), the findings of the inspection, and the disposition or scheduling of repairs or maintenance found necessary during the inspection. For each inspection unit, the records of vegetation management shall include the date(s) during which the work was conducted. The records shall be kept until two years after the next periodic inspection or vegetation management action is completed or until all necessary repairs and maintenance are completed, whichever is longer.

**25.3(5) Guidelines.** Applicable portions of Rural Utilities Service (RUS) Bulletins 1730-1, 1730B-121, and 1724E-300 and “The Lineman’s and Cableman’s Handbook” are suggested as guidelines for the development and implementation of an inspection plan. ANSI A300 (Part 1)-2001, “Pruning,” and Section 35 of “The Lineman’s and Cableman’s Handbook” are suggested as guides for tree trimming practices.

#### **199—25.4(476,478) Correction of problems found during inspections and pole attachment procedures.**

**25.4(1)** Corrective action shall be taken within a reasonable period of time on all potentially hazardous conditions, instances of safety code noncompliance, maintenance needs, potential threats to safety and reliability, or other concerns identified during inspections. Hazardous conditions shall be corrected promptly. In addition to the general requirements stated in this subrule, pole attachments shall comply with the specific requirements and procedures established in subrule 25.4(2).

**25.4(2)** To ensure the safety of pole attachments to poles owned by utilities in Iowa, this subrule establishes requirements for attaching electric lines, communications lines, cable systems, video service lines, data lines, wireless antennae and other wireless facilities, or similar lines and facilities that are attached to the excess space on poles owned by utilities.

*a. Definitions.* The following definitions shall apply to this rule.

“*Pole*” means any pole owned by a utility that carries electric lines, communications lines, cable systems, video service lines, data service lines, wireless antennae or other wireless facilities, or similar lines and facilities.

“*Pole attachment*” means any electric line, communication circuit, cable system, video service line, data service line, antenna and other associated wireless equipment, or similar lines and facilities attached to a pole or other supporting structure subject to the safety jurisdiction of the board pursuant to the Iowa electrical safety code, 199—25.2(476,476A,478).

“*Pole occupant*” means any electric utility, telecommunications carrier, cable system provider, video service provider, data service provider, wireless service provider, or similar person or entity that constructs, operates, or maintains pole attachments as defined in this chapter.

“*Pole owner*” means a utility that owns poles subject to the safety jurisdiction of the board pursuant to the Iowa electrical safety code, 199—25.2(476,476A,478).

*b. Compliance with Iowa electrical safety code.* Pole attachments to poles shall be constructed, installed, operated, and maintained in compliance with the Iowa electrical safety code, 199—25.2(476,476A,478), and the requirements and procedures established in this subrule.

*c. Requests for access to poles; exceptions for service drops and overlashing.*

(1) A pole owner shall provide nondiscriminatory access to poles it owns, to the extent required by federal or state law. Requests for access to poles by an electric utility, telecommunications carrier, cable system operator, video service provider, data service provider, wireless service provider, or similar person or entity shall be made in writing or by any method as may be agreed upon by the pole owner and the person or entity requesting access to the pole. If access is denied, the pole owner shall explain in detail the specific reason for denial and how the denial relates to reasons of lack of capacity, safety, reliability, or engineering standards.

(2) Service drops are not subject to the notice and approval requirements in subparagraph 25.4(2)“c”(1). Instead, pole occupants shall provide notice to pole owners within 30 days of the installation of a new service drop, unless the pole occupant and pole owner have negotiated a different notification requirement.

(3) Overlashing of existing lines is not subject to the notice and approval requirements in subparagraph 25.4(2)“c”(1). Pole occupants shall provide notice to pole owners of proposed overlashing at least 7 days prior to installation of the overlashing, unless the pole occupant and pole owner have negotiated a different notification requirement.

*d. Notification of violation.* A pole owner shall notify in writing a pole occupant of an alleged violation of the Iowa electrical safety code by a pole attachment owned by the pole occupant or may provide notice by another method as may be agreed upon by the parties to a pole attachment agreement. The notice shall include the address and pole location where the alleged violation occurred, a description of the alleged violation, and suggested corrective action.

*e. Corrective action.*

(1) Upon receipt of notification from a pole owner that the pole occupant has one or more pole attachments in violation of the Iowa electrical safety code, the pole occupant shall respond to the pole owner within 60 days in writing or by another method as may be agreed upon by the pole occupant and the pole owner. The response shall provide a plan for corrective action, state that the violation has been corrected, indicate that the pole attachment is owned by a different pole occupant, or indicate that the pole occupant disputes that a violation has occurred. The violation shall be corrected within 180 days of the date notification is received unless good cause is shown for any delay in taking corrective action. A disagreement that a violation has occurred, a claim that correction is not possible within the specific time frames due to events beyond the control of the pole occupant, or a claim that a different pole occupant is responsible for the alleged violation will be considered good cause to extend the time for taking corrective action. The pole occupant and pole owner may also agree to an extension of the time for taking corrective action. The pole owner and pole occupant shall cooperate in determining the cause of a violation and an efficient and cost-effective method of correcting a violation.

(2) If the violation could reasonably be expected to endanger life or property, the pole occupant shall take the necessary action to correct, disconnect, or isolate the problem immediately upon notification. If immediate corrective action is not taken by the pole occupant for a violation that could reasonably be expected to endanger life or property, the pole owner may take the necessary corrective action and the pole occupant shall reimburse the pole owner for the actual cost of any corrective measures. If the pole owner is later determined to have caused the violation and the pole occupant has taken corrective action, the pole owner shall reimburse the pole occupant for the actual cost of the corrective action. Disputes concerning the ownership of the pole attachment should be resolved as quickly as possible.

*f. Negotiated resolution of disputes.* Parties to disputes over alleged violations of the Iowa electrical safety code, the cause of a violation, the pole occupant responsible for the violation, the cost-effective corrective action, or any other dispute regarding the provisions of subrule 25.4(2) shall attempt to resolve disputes through good-faith negotiations. Parties may file an informal complaint with the board pursuant to 199—Chapter 6 as part of negotiations.

*g. Complaints.* Complaints concerning the requirements or procedures established in subrule 25.4(2), including alleged violations of the Iowa electrical safety code, may be filed with the board by pole owners or pole occupants pursuant to the complaint procedures in 199—Chapter 6.

*h. Civil penalties.* Persons found to have violated the provisions of subrule 25.4(2) may be subject to civil penalties pursuant to Iowa Code section 476.51 or to other action by the board.

[ARC 1259C, IAB 1/8/14, effective 2/12/14]

**199—25.5(476,478) Accident reports.** This rule applies to all owners or operators of electrical facilities subject to the safety jurisdiction of the board under this chapter.

**25.5(1)** All owners and operators of electrical facilities subject to the safety jurisdiction of the board shall provide the board with a 24-hour contact number where the board can obtain immediate access to a person knowledgeable about any incidents involving contact with energized electrical facilities.

**25.5(2)** All owners and operators of electrical facilities subject to the safety jurisdiction of the board shall notify the board of any incident or accident involving contact with energized electrical facilities that meets the following conditions:

*a.* An employee or other person coming in contact with energized electrical facilities which results in death or personal injury necessitating in-patient hospitalization.

*b.* Estimated property damage of \$15,000 or more to the property of the utility and others.

*c.* Any other incident considered significant by the company.

**25.5(3)** The board shall be notified by telephone immediately, or as soon as practical thereafter, by calling the board duty officer at (515)745-2332 or by E-mail to [iubdutyofficer@iub.iowa.gov](mailto:iubdutyofficer@iub.iowa.gov). The caller shall leave a telephone number of a person who can provide the following information:

*a.* The name of the company, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the incident.

*b.* The location of the incident.

*c.* The time of the incident.

*d.* The number of deaths or personal injuries requiring in-patient hospitalization and the extent of those injuries.

*e.* Initial estimate of damages.

*f.* A summary of the significant information available regarding the probable cause of the incident and extent of damages.

*g.* Any oral or written report made to a federal agency, the agency receiving the report, and the name and telephone number of the person who made or prepared the report.

**25.5(4)** Written incident reports. Within 30 days of the date of the incident, the owner or operator shall file a written report with the board. The report shall include the information required for telephone notice in subrule 25.5(3), the probable cause as determined by the company, the number and cause of any deaths or personal injuries requiring in-patient hospitalization, and a detailed description of property damage and the amount of monetary damages. If significant additional information becomes available at a later date, a supplemental report shall be filed. Duplicate copies of any written reports filed with or submitted to a federal agency concerning the incident shall also be provided to the board.

[Editorial change: IAC Supplement 12/29/10]

These rules are intended to implement Iowa Code chapter 478.

[Filed 4/10/79, Notices 5/3/78, 8/23/78—published 5/2/79, effective 6/6/79]

[Filed 11/19/82, Notice 9/1/82—published 12/8/82, effective 1/12/83]

[Filed 1/28/83, Notice 12/8/82—published 2/16/83, effective 3/23/83]

[Filed emergency 9/18/86—published 10/8/86, effective 9/18/86]

[Filed 11/18/91, Notice 4/17/91—published 12/11/91, effective 1/15/92]

[Filed 7/15/92, Notice 12/11/91—published 8/5/92, effective 9/9/92]<sup>o</sup>

[Filed 10/20/94, Notice 6/22/94—published 11/9/94, effective 12/14/94]

[Filed 10/31/97, Notice 5/7/97—published 11/19/97, effective 12/24/97]

[Filed 10/13/99, Notice 5/19/99—published 11/3/99, effective 12/8/99]

[Filed 3/29/02, Notice 2/6/02—published 4/17/02, effective 5/22/02]

[Filed 10/25/02, Notice 3/6/02—published 11/13/02, effective 12/18/02]

[Filed 4/24/03, Notice 12/11/02—published 5/14/03, effective 6/18/03]

[Filed 9/24/04, Notice 8/18/04—published 10/13/04, effective 11/17/04]

[Filed 5/2/07, Notice 3/28/07—published 5/23/07, effective 6/27/07]

[Filed 6/14/07, Notice 12/20/06—published 7/4/07, effective 8/8/07]

[Filed 12/27/07, Notice 9/26/07—published 1/30/08, effective 3/5/08]

[Filed ARC 7962B (Notice ARC 7749B, IAB 5/6/09), IAB 7/15/09, effective 8/19/09]

[Editorial change: IAC Supplement 12/29/10]

[Filed ARC 9501B (Notice ARC 9394B, IAB 2/23/11), IAB 5/18/11, effective 6/22/11]

[Filed ARC 1259C (Notice ARC 0784C, IAB 6/12/13), IAB 1/8/14, effective 2/12/14]

◇ Two or more ARCs



## **HUMAN SERVICES DEPARTMENT[441]**

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

### TITLE I

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[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]

[Prior to 7/1/83, Social Services[770] Ch 7]

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PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department. The definitions in rule 441—7.1(17A) apply to the rules in both Division I and Division II of Chapter 7. [ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.1(17A) Definitions.**

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

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

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

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

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

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

2. For food assistance, a person:

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

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

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Whose eligibility has been terminated, suspended or reduced.
- Who has been notified that there will be a reduction in the level of benefits or services the person is eligible to receive.

- Who has received a determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing.
  - Who has been notified that the level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.
  - Who has been notified that level of care requirements have not been met.
  - Who has been aggrieved by a failure to take into account the appellant's choice in assignment to a coverage group.
  - Who contests the effective date of assistance or services.
  - Who contests the amount or effective date of health insurance premium payments, healthy and well kids in Iowa premium payments, Medicaid for employed people with disabilities premium payments, IowaCare premium payments, or the spenddown amount under the medically needy program.
  - Who contests the amount of client participation.
  - Whose claim for payment or prior authorization has been denied.
  - Who has been notified that the reconsideration process has been exhausted and who remains dissatisfied with the outcome.
  - Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by medical assistance.
  - Who has been notified that an overpayment of benefits has been established and repayment is requested.
  - Who has been denied requested nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) and has exhausted the grievance procedures established by the broker pursuant to 441—subrule 78.13(7).
4. For social services, including, but not limited to, adoption, foster care, and family-centered services, a person (see numbered paragraph “7” for providers):
- Whose request to be given an application was denied.
  - Whose application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.
  - For whom it is determined that the person must participate in a service program.
  - Whose claim for payment of services has been denied.
  - Who has been notified that a protective or vendor payment will be established.
  - Who has been notified that there will be a reduction or cancellation of services.
  - Who has been notified that an overpayment of services has been established and repayment is requested.
  - Who applies for an adoption subsidy after the adoption has been finalized.
  - Who alleges that the adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.
  - Who has not been referred to community care as provided in rule 441—186.2(234).
  - Who has been referred to community care as provided in rule 441—186.2(234) and has exhausted the community care provider's dispute resolution process.
  - Who has been referred to aftercare services under 441—Chapter 187 and has exhausted the aftercare provider's dispute resolution process.
5. For child support recovery, a person:
- Who is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or whose dispute based on the date of collection has not been acted on in a timely manner.
  - Who is contesting a claim or offset as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by alleging a mistake of fact. “Mistake of fact” means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.
  - Whose name has been certified for passport sanction as provided in Iowa Code section 252B.5.

- Who has been notified that there will be a termination in services as provided in rule 441—95.14(252B).

6. For PROMISE JOBS, a person:

- Whose claim for participation allowances has been denied, reduced, or canceled.
- Who claims that the contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.
- Who is dissatisfied with the results of informal grievance resolution procedures, or who fails or refuses to receive informal grievance resolution procedures.
- Who has been notified that PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.
- Who alleges acts of discrimination on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.
- Who claims displacement by a PROMISE JOBS participant.

7. For providers, a person or entity:

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

- Who has been subject to an adverse action related to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A).

- Who, as a managed care organization (MCO) provider or Iowa plan contractor when acting on behalf of a member, has a dispute regarding payment of claims.

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

- Who is a person alleged responsible for child abuse.
- Who has requested correction of dependent adult abuse information.
- Who has been restricted from or denied employment in a health care facility, state institution, or other facility based on a record check. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facilities" include, but are not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.

- Who is contesting a risk assessment decision as provided in rule 441—103.34(692A) by alleging that the risk assessment factors have not been properly applied, the information relied upon to support the assessment findings is inaccurate, or the procedures were not correctly followed.

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

- Whose application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.
- Who has been notified that there will be a reduction or cancellation of services under the state payment program.

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

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

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

12. Bidders that have participated in a competitive procurement bid process. Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

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

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

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

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

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

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

“*Authorized representative*” means a person or organization designated by an appellant to act on the appellant’s behalf or who has legal authority to act on behalf of the appellant, such as a guardian or power of attorney.

“*Bidder*” means an individual or entity that submits a proposal in response to a competitive procurement issued by the department.

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

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

“*Department of inspections and appeals*” means the state agency that contracts with the department to conduct appeal hearings.

“*Director*” means the director of the department of human services or the director’s designee.

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

“*Electronic account*” means a Web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

“*Electronic case record*” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid or healthy and well kids in Iowa eligibility and enrollment, including all documentation required for eligibility and any information collected or generated as part of a fair hearing process conducted by the department or through the exchange appeals process.

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

*“Exchange”* means an American health benefit exchange established pursuant to Section 1311 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148). This entity makes qualified health plans available to qualified individuals and qualified employers.

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

*“Group hearings”* denotes an opportunity for two or more persons to present their case jointly when all have the same complaint against agency policy.

*“Informal conference”* means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, and a representative of the department. The purpose of the informal conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant’s action or position, and to provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9.

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

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

*“Local office”* means the county, institution or district office of the department of human services.

*“Party”* means a party as defined in Iowa Code subsection 17A.2(8).

*“Prehearing conference”* means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, a representative of the department and a presiding officer. The purpose of the prehearing conference is to discuss the appealed issue, to inquire as to the potential for voluntary settlement, to establish the hearing date, to establish the location of the hearing including whether the hearing will be by telephone or in person, and to discuss procedural matters relevant to the case.

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

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

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

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

*“Proposed decision”* means the presiding officer’s recommended findings of fact, conclusions of law, and decision and order in contested cases where the department did not preside.

*“Reconsideration”* means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through:

1. The Iowa Medicaid enterprise (IME) or its subcontractors,
2. The managed health care review committee,
3. A division or bureau within the department,
4. The mental health and disability services commission,
5. A licensed health care professional as specified in 441—paragraph 9.9(1)“i,” or
6. Any division or bureau within the department, from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a notice of decision will be issued with appeal rights.

*“Sent”* means deposited in the mail with first-class postage or posted to an individual’s electronic account.

*“Teleconference hearing”* means an appeal hearing conducted by an administrative law judge over the telephone.

*“Timely notice period”* is the time from the date a notice is sent to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of a beneficiary. When probable fraud exists, “timely notice period” shall be at least five calendar days from the date a notice is sent.

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

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0583C, IAB 2/6/13, effective 4/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 1261C, IAB 1/8/14, effective 3/1/14]

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

#### DIVISION I

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

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

**7.4(1)** Hearing procedures must be furnished in electronic and paper format and orally as appropriate. The procedures must be written in plain language and in a manner that is accessible:

*a.* To individuals who are limited English proficient through oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services. The services shall be at no cost to the individual.

*b.* To individuals living with disabilities through the provision of auxiliary aids in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The services shall be at no cost to the individual.

**7.4(2)** The department shall inform individuals of the availability of the services and how to access such services.

[ARC 1261C, IAB 1/8/14, effective 3/1/14]

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

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

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

*a.* One of the following issues is appealed:

(1) The service is no longer available through the department.  
(2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(18) An MCO provider or Iowa plan contractor fails to submit a document providing the member's approval of the request for appeal.

(19) Notice was issued by the exchange regarding determination of eligibility for enrollment in a qualified health plan or for advance payment of the premium tax credit or cost-sharing reductions.

(20) Notice has been issued regarding the completion of a family assessment that indicates no determination of child abuse or neglect has been made and no information has been reported to the child abuse registry.

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

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

*d.* The appeal is filed prematurely as:

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

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

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

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

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

*h.* The issue appealed is moot.

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

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

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

*a. General standards.* In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

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

1. There was a serious illness or death of the appellant or a member of the appellant’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant’s control, which can be substantiated.
4. There was a failure to receive the department’s notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

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

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

*b. Food assistance, Medicaid or healthy and well kids in Iowa standard.* For appeals regarding food assistance, Medicaid or the healthy and well kids in Iowa program, a hearing shall be held if the appeal is made within 90 days after official notification of an action.

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

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

1. There was a serious illness or death of the appellant or a member of the appellant’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant’s control, which can be substantiated.
4. There was a failure to receive the department’s notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

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

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

*d. Abuse standard.*

(1) For appeals regarding dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235B.10.

(2) For appeals regarding child abuse, a hearing shall be held if the appeal is made by a person alleged responsible for the abuse within 90 days after official notification of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the hearing within 10 calendar days after the appeal notification.

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

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

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

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

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

**7.5(5) Informal settlements.** The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress.

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

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

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

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

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

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

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

- (1) Form 470-2891, Notice of Medical Assistance Overpayment; or
- (2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Overpayment.

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

**7.5(8) Appeal rights under the family investment program limited benefit plan.** A participant only has the right to appeal the establishment of the limited benefit plan once at the time the department issues

the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on an incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

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

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

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

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

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

- (1) Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance;
- (2) Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance; or
- (3) Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance.

*b.* Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a food assistance overpayment.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 9698B, IAB 9/7/11, effective 8/15/11; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0583C, IAB 2/6/13, effective 4/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

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

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

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

- (1) The right to request a hearing.
- (2) The procedure for requesting a hearing.
- (3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.
- (4) Provisions, if any, for payment of legal fees by the department.

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

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

*d.* Persons living with disabilities shall be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

**7.6(2) Authorized representation or responsible party.** Persons may be represented for purposes of this chapter by an authorized representative or an individual or organization recognized by the department as acting responsibly for an applicant or beneficiary pursuant to policy governing a particular program (hereinafter referred to as a "responsible party"), unless otherwise specified by statute or federal regulations.

*a.* The designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person.

*b.* An authorized representative or responsible party must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or beneficiary provided by the department.

*c.* A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must sign an agreement that such provider, staff member or volunteer will adhere to the regulations in Part 431, Subpart F, of 42 CFR Chapter IV and in 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflict of interest and confidentiality of information.

*d.* An authorized representative or responsible party may file an appeal on the appellant's behalf, receive copies of appeal correspondence, and act on behalf of the appellant in all other matters regarding the appeal.

*e.* The authorized representative or responsible party is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible party represents.

*f.* The power to act as an authorized representative is valid until the appellant modifies the authorization or notifies the department that the representative is no longer authorized to act on the appellant's behalf, or the authorized representative informs the agency that the authorized representative is no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and include the appellant's, authorized representative's or responsible party's signature as appropriate.

*g.* Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted online via the department's Web site, by mail, by electronic mail, by facsimile transmission or in person.

*h.* For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission.

*i.* Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority previously submitted to the department that comply with the requirements of this rule will continue to apply for purposes of appeals, consistent with their terms.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14]

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

##### **7.7(1) Notification.**

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

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

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

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

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

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

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

- (1) A statement of what action is being taken,
- (2) The effective date of such action,
- (3) A clear statement of the specific reasons supporting the intended action,
- (4) The manual chapter number and subheading supporting the action and the corresponding rule reference,
- (5) An explanation of the appellant's right to appeal, and
- (6) The circumstances under which assistance is continued when an appeal is filed.

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

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

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

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

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

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

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

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

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

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

j. The notice involves an adverse determination made with regard to the preadmission screening requirements.

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

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

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

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

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

**7.7(4) *Conference during the timely notice period.*** Rescinded IAB 7/10/13, effective 9/1/13.

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

- a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.
- b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.
- c. When the placement of a person(s) in foster care is changed.
- d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.
- e. When services of the community self-sufficiency grant project are available to all PROMISE JOBS participants as specified in 441—subrule 47.46(1).

**7.7(6) Reinstatement.**

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

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

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

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

#### **441—7.8(17A) Opportunity for hearing.**

**7.8(1) Initiating an appeal.** To initiate an appeal, a person, the person's authorized representative or an individual or organization recognized by the department as acting responsibly for the person pursuant to policy governing a particular program must state in writing that the person disagrees with a decision, action, or failure to act on the person's case.

a. All appeals shall be made in writing, except for food assistance, Medicaid and healthy and well kids in Iowa appeals, which may be made by telephone or in person.

b. A written request may be submitted via the department's Web site or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.

c. A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.

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

A written appeal submitted by mail is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

**7.8(3) Informal conference.** When requested by the appellant, an informal conference with a representative of the department shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

An informal conference need not be requested for the appellant to examine the contents of the case record, including any electronic case record, as provided in subrule 7.13(1) and 441—Chapter 9.

**7.8(4) *Prehearing conference.*** When requested by the appellant or department, a prehearing conference may be held with the appellant, a representative of the department and a presiding officer as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the prehearing conference, unless precluded by federal rule or state statute.

**7.8(5) *Interference.*** Neither an informal conference nor a prehearing conference shall be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

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

- a. It has been withdrawn by the appellant pursuant to subrule 7.8(8).
- b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.
- c. It has been abandoned.
- d. The agency, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.
- e. The agency implements action and issues a notice of decision or notice of action to correct an error made by the agency which resulted in the appeal.

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

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

**7.8(8) *Withdrawal.*** When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall accept a request from the appellant to withdraw the appeal by telephone, in writing or in person. A written request may be submitted in person, by mail or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose. For child abuse and dependent adult abuse appeals, the request to withdraw an appeal must be made in writing and signed by the appellant or the appellant's legal counsel.

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

- a. Within one working day of receipt, complete the worker information section of Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and forward that form, the written appeal, the postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.
- b. Forward a summary and supporting documentation of the worker's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.
- c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

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

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

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

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

- (1) Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS).
- (2) Medicaid Review, Form 470-3118, 470-3118(S), 470-3118(M), or 470-3118(MS).

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

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

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

*a.* An appeal is not filed within the timely notice period or within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

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

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

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

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

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

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

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

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

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

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

*c.* The department's action is affirmed.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14]

#### **441—7.10(17A) Procedural considerations.**

**7.10(1)** *Registration.* Upon receipt of the notice of appeal, the department shall register the appeal.

**7.10(2)** *Acknowledgment.*

*a.* Upon receipt of the notice of appeal, the department shall send an acknowledgment of receipt of the appeal to the appellant, representative, or both. A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

b. For an appeal regarding child abuse, all subjects other than the person alleged responsible (appellant) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

c. The department shall advise the person of any legal services which may be available and that the person may be represented by counsel at the person's own expense.

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

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

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

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

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

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

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

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

e. Emergency assistance appeals shall be expedited.

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

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

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

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

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

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

- (1) The date, time, method and place of the hearing;
- (2) That evidence may be presented orally or documented to establish pertinent facts; and

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

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

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

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

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

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

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

**7.13(1) Examination of the evidence.** The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 441—9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.

**7.13(2) Conduct of hearing.**

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

b. For an appeal hearing regarding child abuse, the administrative law judge, upon request of any party to the hearing, may stay the hearing until the conclusion of the adjudicatory phase of a pending juvenile or district court case relating to the data or findings as provided in Iowa Code section 235A.19.

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

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

a. Where appropriate and not contrary to law, any party may move for a default decision against a party who has failed to file a required pleading or has failed to appear after proper service for a hearing. A proposed decision on the merits may be issued in the absence of a defaulting party.

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

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

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

**7.13(5) Proceedings after default decision.**

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

b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact. Each affidavit must be attached to the motion. In lieu of an affidavit, the moving party may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

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

c. 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.

d. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).
2. Death or serious illness in the party's immediate family.
3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.
2. Confusion as to the date and time for the hearing.
3. Failure to follow the directions on the notice of hearing.
4. Oversleeping.
5. Other acts demonstrating a lack of due care by the party.

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

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

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

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

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

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

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

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

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

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

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

*d.* 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.

*e.* "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party's immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.

2. Confusion as to the date and time for the hearing.

3. Failure to follow the directions on the notice of hearing.

4. Oversleeping.

5. Other acts demonstrating a lack of due care by the party.

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

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

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

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

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

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13]

**441—7.14(17A) Limitation of persons attending.**

**7.14(1)** The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant's representative, agency employees, agency's legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing. Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens' group to attend the hearing without the written consent of the appellant.

**7.14(2)** For an appeal hearing regarding child abuse:

*a.* Subjects who file a motion to intervene, as provided in Iowa Code section 235A.19, will have the opportunity to appear at the prehearing conference. Any motion to intervene shall be considered by the administrative law judge at the prehearing conference.

*b.* The department shall not be considered to be a party who can adequately represent the interests of any other subject.

*c.* Subjects allowed to intervene as specified in subrule 7.5(4) will be considered parties to the hearing and will be allowed to attend the proceedings as provided in Iowa Code section 235A.19.

[ARC 0487C, IAB 12/12/12, effective 2/1/13]

**441—7.15(17A) Medical examination.** When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

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

**441—7.16(17A) The appeal decision.**

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

*a.* The notice of appeal.

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

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

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

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

*a.* The appellant, appellant's representative, a subject allowed to intervene as specified in subrule 7.5(4), the representative of a subject allowed to intervene as specified in subrule 7.5(4), or the department may appeal for the director's review of the proposed decision.

*b.* When the appellant, a subject allowed to intervene as specified in subrule 7.5(4), or the department has not appealed the proposed decision or when an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

*c.* The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in

a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

**7.16(5) *Time limit for appeal of a proposed decision.*** Appeal for the director's review of the proposed decision must be made in writing to the director. The written request must be mailed or submitted in person or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The request must be postmarked or received within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

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

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

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

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

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

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

**7.16(9) *Time limits.***

*a.* A final decision on the appeal shall be issued within the following time frames:

(1) Appeals for all programs, except food assistance and vendors, shall be rendered within 90 days from the date of the appeal.

(2) Food assistance-only decisions shall be rendered within 60 days.

(3) PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

*b.* Failure to reach a decision within the time frames set forth in paragraph 7.16(9) "a" shall not affect the merits of the appellant's appeal.

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

*d.* For an appeal regarding child abuse, if the proposed decision is not appealed within 10 days from the date of the proposed decision, the proposed decision shall be the final agency action. If a party files an appeal within 10 days from the date of the proposed decision, the director has 45 days from the date of the proposed decision to issue a ruling. If the director does not rule within that 45-day period, the proposed decision becomes the final decision as provided in Iowa Code section 235A.19.

*e.* The department shall take prompt, definite and final administrative action to carry out the decision rendered within seven calendar days of receipt of a copy of the final decision. When the final decision is favorable to the appellant, or when the department decides in favor of the appellant before

the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

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

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

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

**441—7.18(17A) Ex parte communication.**

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

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

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

c. For purposes of this rule:

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

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

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

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

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

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

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

party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

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

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

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

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

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

**7.20(2) Stays of agency action.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The proposed and final hearing decisions shall be made in accordance with rule 441—7.16(17A) unless otherwise specified.

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

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

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

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

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

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

**441—7.23(17A) Contested cases with no factual dispute.** If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall

jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

**441—7.24(17A) Emergency adjudicative proceedings.**

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

- a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.
- e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

**7.24(2) Issuance of order.**

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

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

- (1) Personal delivery.
- (2) Certified mail, return receipt requested, to the last address on file with the department.
- (3) Certified mail to the last address on file with the department.
- (4) First-class mail to the last address on file with the department.
- (5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

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

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

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

**441—7.25 to 7.40** Reserved.

DIVISION II  
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

**441—7.41(17A) Scope and applicability.** The rules in Division II apply to appeals based on the department's competitive procurement bid process.  
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.42(17A) Requests for timely filing of an appeal.** Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process, is considered an aggrieved party and may file a written appeal with the department.

**7.42(1)** An aggrieved party in a competitive procurement must seek reconsideration of a disqualification or a notice of award prior to filing any appeal. The request for reconsideration must be received by the department within five days of the date of either a disqualification notice or notice of award. The department will expeditiously address the request for reconsideration and issue a decision on the reconsideration. If the party seeking reconsideration continues to be an aggrieved party following receipt of the decision on reconsideration, the aggrieved party may file an appeal within five days of the date of the department's decision on reconsideration.

**7.42(2)** The written appeal shall state the grounds upon which the appellant challenges the department's decision.

**7.42(3)** The day after the department's decision on reconsideration is issued is the first day of the period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, e-mail, or in-person delivery.  
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.43(17A) Bidder appeals.** The bidder appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of Division II. Division I of this chapter does not apply to competitive procurement bid appeals, unless otherwise noted.

**7.43(1) Hearing time frame.** The presiding officer shall hold a hearing on the bidder appeal within 60 days of the date the notice of appeal was received by the department.

**7.43(2) Registration.** Upon receipt of the notice of appeal, the department shall register the appeal.

**7.43(3) Acknowledgment.** Upon receipt of the notice of appeal, the department shall send a written acknowledgment of receipt of the appeal to the appellant, representative, or both. The appropriate department staff will be notified of the appeal.

**7.43(4) Granting a hearing.** The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at the hearing in accordance with the applicable rules, statutes or federal regulations or request for proposal.

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

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

**7.43(5) Hearing scheduled.** For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in the department of inspections and appeals rules in 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

**7.43(6) Method of hearing.** The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A).

**7.43(7) Reschedule requests.** Requests made by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals, except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals. All requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

**7.43(8) Notification.** For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

*a.* The notice shall comply with Iowa Code section 17A.12(2), and include a statement that opportunity shall be afforded to all parties to respond and present evidence on all issues involved and to be represented by counsel at their own expense.

*b.* A copy of this notice shall be made available to the department employee who took the action and to any other parties to the appeal.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

#### **441—7.44(17A) Procedures for bidder appeal.**

**7.44(1) Discovery.** The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

**7.44(2) Witnesses and exhibits.** The parties shall contact each other regarding witnesses and exhibits at least ten days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

**7.44(3) Amendments to notice of appeal.** The aggrieved bidder may amend the grounds upon which the bidder challenges the department's award no later than 15 days prior to the date set for the hearing.

**7.44(4)** If the hearing is not conducted in person, the parties must deliver all exhibits to the office of the presiding officer at least three days prior to the time the hearing is conducted.

**7.44(5)** The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to the appellant and representative by mail.

**7.44(6)** The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

#### **441—7.45(17A) Stay of agency action for bidder appeal.**

**7.45(1) When a stay may be requested.**

*a.* Any party appealing the issuance of a notice of disqualification or notice of award may petition for stay of the decision pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

*b.* Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order and shall state the reasons justifying a stay.

**7.45(2) When a stay is granted.** In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5)“c.”

**7.45(3) Vacation.** A stay may be vacated by the issuing authority upon application of the department or any other party.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.46(17A) Request for review of the proposed decision.** A request for review of the proposed decision shall follow the provisions outlined in subrules 7.16(5) to 7.16(7).

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.47(17A) Other procedural considerations.****7.47(1) Consolidation—severance.**

*a. Consolidation.* The presiding officer may, upon motion by any party or the presiding officer's own motion, consolidate any or all matters at issue in two or more contested case proceedings where:

- (1) The matters at issue involve common parties or common questions of fact or law;
- (2) Consolidation would expedite and simplify consideration of the issues; and
- (3) Consolidation would not adversely affect the rights of parties to those proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

*b. Severance.* The presiding officer may, upon motion by any party or upon the presiding officer's own motion, for good cause shown, order any proceeding or portion thereof severed.

**7.47(2) Presiding officer.** Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals pursuant to rule 441—7.3(17A).

**7.47(3) Rights of appellants during hearings.** All rights afforded appellants at rule 441—7.13(17A) shall apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.48(17A) Appeal record.**

**7.48(1)** The appeal record shall consist of all items specified in subrule 7.16(1).

**7.48(2)** The party that requests a transcription of the proceedings shall bear the cost.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.49(17A) Pleadings.**

**7.49(1)** Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

**7.49(2) Petition.** When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

*a.* Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

*b.* The petition shall state in separately numbered paragraphs the following:

- (1) On whose behalf the petition is filed;
- (2) The particular provisions of the statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

**7.49(3) Answer.** If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

*a.* Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

*b.* The answer shall show on whose behalf it is filed and specifically admit, deny or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and may contain as many defenses as the pleader may claim.

*c.* The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

*d.* Any allegation in the petition 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.

**7.49(4) Amendment.** Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.50(17A) Ex parte communications.** The rules regarding ex parte communications listed at 441—7.18(17A) apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.51(17A) Right of judicial review.** The rules regarding right of judicial review listed at 441—7.20(17A) apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

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

- [Filed December 27, 1971; amended December 2, 1974]
- [Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 7/1/76]
- [Filed 9/29/76, Notice 8/23/76—published 10/20/76, effective 11/24/76]
- [Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
- [Filed 5/8/78, Notice 10/19/77—published 5/31/78, effective 7/5/78]
- [Filed emergency 3/30/79—published 4/18/79, effective 3/30/79]
- [Filed 5/5/80, Notice 2/20/80—published 5/28/80, effective 7/2/80]
- [Filed 10/23/80, Notice 9/3/80—published 11/12/80, effective 12/17/80]
- [Filed 6/2/81, Notice 3/18/81—published 6/24/81, effective 8/1/81]
- [Filed 7/1/82, Notices 10/28/81, 12/23/81—published 7/21/82, effective 8/25/82]
- [Filed 7/1/82, Notice 5/12/82—published 7/21/82, effective 9/1/82]
- [Filed 10/28/83, Notice 8/17/83—published 11/23/83, effective 1/1/84]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
- [Filed 5/4/84, Notice 2/29/84—published 5/23/84, effective 7/1/84]
- [Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
- [Filed 7/26/85, Notice 6/5/85—published 8/14/85, effective 10/1/85]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 1/15/87, Notice 12/3/86—published 2/11/87, effective 4/1/87]
- [Filed emergency 7/14/89 after Notice 5/31/89—published 8/9/89, effective 8/1/89]
- [Filed 11/16/89, Notice 9/20/89—published 12/13/89, effective 2/1/90]
- [Filed 1/16/90, Notice 11/15/89—published 2/7/90, effective 4/1/90]
- [Filed emergency 10/10/91 after Notice 8/21/91—published 10/30/91, effective 11/1/91]
- [Filed 1/16/92, Notice 9/18/91—published 2/5/92, effective 4/1/92]
- [Filed 1/16/92, Notice 11/27/91—published 2/5/92, effective 4/1/92]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 2/10/94, Notice 12/8/93—published 3/2/94, effective 5/1/94]
- [Filed 10/12/94, Notice 8/17/94—published 11/9/94, effective 1/1/95]
- [Filed without Notice 9/25/95—published 10/11/95, effective 12/1/95]
- [Filed emergency 11/16/95—published 12/6/95, effective 12/1/95]
- [Filed emergency 1/10/96 after Notice 10/11/95—published 1/31/96, effective 2/1/96]
- [Filed 1/10/96, Notice 10/11/95—published 1/31/96, effective 4/1/96]
- [Filed 8/15/96, Notice 5/8/96—published 9/11/96, effective 11/1/96]
- [Filed 10/9/96, Notice 8/14/96—published 11/6/96, effective 1/1/97]
- [Filed emergency 9/16/97—published 10/8/97, effective 10/1/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]◊
- [Filed 12/10/97, Notice 10/8/97—published 12/31/97, effective 3/1/98]
- [Filed 6/10/98, Notice 5/6/98—published 7/1/98, effective 8/5/98]
- [Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 5/31/99]

- [Filed 4/15/99, Notice 2/24/99—published 5/5/99, effective 7/1/99]
- [Filed 9/12/00, Notice 7/12/00—published 10/4/00, effective 12/1/00]
- [Filed 2/14/01, Notice 11/29/00—published 3/7/01, effective 5/1/01]
- [Filed 5/9/01, Notice 2/21/01—published 5/30/01, effective 7/4/01]
- [Filed 4/10/03, Notice 2/19/03—published 4/30/03, effective 7/1/03]
- [Filed 9/22/03, Notice 7/23/03—published 10/15/03, effective 12/1/03]
- [Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
- [Filed 5/14/04, Notice 3/31/04—published 6/9/04, effective 7/14/04]
- [Filed emergency 7/9/04—published 8/4/04, effective 7/9/04]
- [Filed 9/23/04, Notice 8/4/04—published 10/13/04, effective 11/17/04]
- [Filed emergency 2/10/05 after Notice 12/22/04—published 3/2/05, effective 3/1/05]
- [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
- [Filed 8/12/05, Notice 6/8/05—published 8/31/05, effective 11/1/05]
- [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
- [Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
- [Filed 11/16/05, Notice 9/14/05—published 12/7/05, effective 2/1/06]
- [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
- [Filed 10/20/06, Notice 8/30/06—published 11/8/06, effective 1/1/07]
- [Filed emergency 11/9/06 after Notice 7/5/06—published 12/6/06, effective 12/1/06]
- [Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]
- [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
- [Filed emergency 12/11/08 after Notice 10/8/08—published 1/14/09, effective 2/1/09]
- [Filed ARC 8003B (Notice ARC 7730B, IAB 4/22/09), IAB 7/29/09, effective 9/2/09]
- [Filed ARC 8439B (Notice ARC 8083B, IAB 8/26/09), IAB 1/13/10, effective 3/1/10]
- [Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
- [Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]
- [Filed Emergency After Notice ARC 9698B (Notice ARC 9589B, IAB 6/29/11), IAB 9/7/11, effective 8/15/11]
- [Filed ARC 0304C (Notice ARC 0132C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]
- [Filed ARC 0487C (Notice ARC 0325C, IAB 9/5/12), IAB 12/12/12, effective 2/1/13]
- [Filed ARC 0583C (Notice ARC 0435C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
- [Filed ARC 0819C (Notice ARC 0671C, IAB 4/3/13), IAB 7/10/13, effective 9/1/13]
- [Filed ARC 1206C (Notice ARC 1000C, IAB 9/4/13), IAB 12/11/13, effective 1/15/14]
- [Filed ARC 1261C (Notice ARC 1129C, IAB 10/16/13), IAB 1/8/14, effective 3/1/14]

◊ Two or more ARCs

CHAPTER 9  
PUBLIC RECORDS AND FAIR  
INFORMATION PRACTICES

PREAMBLE

These rules describe the records of the Iowa department of human services and procedures for access to these records. All records of the department are open to the public except those that the department is authorized or required by law to keep confidential.

These rules also implement the federal Health Insurance Portability and Accountability Act (HIPAA) regulations at 45 CFR Parts 160 and 164 as amended to August 14, 2002. These rules set forth the standards the department of human services must meet to protect the privacy of protected health information. The department has chosen to be considered a hybrid entity for purposes of HIPAA because there are parts of the department that are not part of the covered entity for purposes of HIPAA compliance.

The rules on protected health information apply only to those parts of the department that are considered part of the covered entity: the named health plans and health care providers defined in these rules and the divisions or programs that perform functions on behalf of a named health plan. Targeted case management, refugee services, and the child support recovery unit are examples of parts of the department that are not included in the covered entity.

**441—9.1(17A,22) Definitions.** As used in this chapter:

*“Business associate”* means a person or organization, other than a member of the department’s workforce, who meets one of the following criteria:

1. Performs, or assists in the performance of, a function or activity on behalf of the department which involves the use or disclosure of protected health information, including claims processing or administration, data analysis, research, utilization review, quality assurance, billing, benefit management, practice management, and repricing, or any other function or activity regulated by the rules on protected health information.
2. Provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the department. The provision of the service shall involve the disclosure of protected health information from the department or from another business associate of the department to the person or organization.

*“Client”* means a person who has applied for or received services or assistance from the department.

*“Confidential record”* means a record which is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include:

1. Records or information contained in records that the department is prohibited by law from making available for examination by members of the public, and
2. Records or information contained in records that is specified as confidential by Iowa Code section 22.7, or other provision of law, but that may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record.

Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

*“Covered entity”* means:

1. A health plan.
2. A health care clearinghouse.
3. A health care provider that transmits any health information in electronic form in connection with a transaction covered by the HIPAA regulations.

*“Covered functions”* means the functions performed by a covered entity which make the covered entity a health plan, health care clearinghouse, or health care provider.

*“Custodian”* means the department or a person who has been given authority by the department to act for the department in implementing Iowa Code chapter 22. For local offices, the custodian is the service area manager. For a child support recovery office, the custodian is the regional administrator.

For an institution, the custodian is the institution superintendent. For a central office unit, or for requests dealing with more than one service area, region, or institution, the custodian is the division administrator.

“*Data aggregation*” means the action by which a business associate combines protected health information of the department with protected health information of another covered entity to permit data analyses that relate to the health care operations of the respective covered entities.

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

“*Designated record set*” means a group of records maintained by or for the department that is:

1. The medical records about subjects that are maintained for facilities;
2. The enrollment, payment, and eligibility record systems maintained for Medicaid; or
3. The enrollment, payment, and eligibility record systems maintained for the HAWK-I program that are used, in whole or in part, by the HAWK-I program to make decisions about subjects.

For purposes of this definition, the term “record” means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for the department.

“*Disclosure*” means releasing, transferring, providing access to, or divulging in any other manner information outside the organization holding the information.

“*Facility*” or “*facilities*” means, with respect to HIPAA rules about health information, one or more of these department institutions: Cherokee Mental Health Institute, Clarinda Mental Health Institute, Glenwood Resource Center, Independence Mental Health Institute, Mount Pleasant Mental Health Institute, and Woodward Resource Center.

“*Health care*” means care, services, or supplies related to the health of a subject. “Health care” includes, but is not limited to, the following:

1. Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedures with respect to the physical or mental condition, or functional status, of a subject or affecting the structure or function of the body; and
2. Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

“*Health care clearinghouse*” means a public or private organization, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that performs either of the following functions:

1. Processes or facilitates the processing of health information received from another organization in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
2. Receives a standard transaction from another organization and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving organization.

“*Health care operations*” has the same definition as that stated in 45 CFR 164.501 as amended to August 14, 2002. For a covered entity in the department, “health care operations” has the following meaning:

1. For Medicaid, “health care operations” means any of the following activities of the department to the extent that the activities are related to covered functions:
  - Conducting quality assessments and evaluating outcomes.
  - Developing clinical guidelines.
  - Improving general health or reducing costs.
  - Developing protocols, including case management and care coordination models for MediPASS and pharmacy case management as well as for other service areas and client populations under the Medicaid program.
  - Informing clients of treatment alternatives and related functions.
  - Reviewing competence or qualifications or performance of health care professionals using the surveillance and utilization review subsystem.
  - Reviewing health plan performance from encounter data.
  - Premium rating and rate setting.

- Performing activities in reinsurance of risk with the health maintenance organizations.
- Reviewing medical level of care and prior authorizations.
- Obtaining legal services through the attorney general's office or the county attorney's office.
- Cooperating in audits and fraud detection by Iowa and federal auditors, the Iowa Medicaid enterprise, or the department of inspections and appeals.
  - Conducting business planning and development including formulary development by the drug utilization review commission and the department's research and statistics staff.
  - Managing activities, which include claiming of federal financial participation, recovering unknown third-party liability, recovering nursing care funds and other expenditures through estate recovery, Grouper programming for hospitals, lock-in activities, and federal reporting of paid claims.
  - Providing customer service, which includes income maintenance workers answering questions about lock-in providers, copayment for pregnant women, and claims payment problems; and the Iowa Medicaid enterprise provider services unit answering questions on claims payment.
  - Coordinating care and monitoring the effective delivery of child welfare services to ensure the safety and well-being of children, including reporting and providing testimony to the court of jurisdiction on the condition and service progress of a client receiving services from the department. These care coordination and monitoring activities include providing information concerning the client to attorneys representing the various parties in the court proceedings.

2. For the HAWK-I program, "health care operations" means any of the following activities of the department to the extent that the activities are related to covered functions:

- Conducting quality assessment and improvement activities, including evaluation of outcomes and development of clinical guidelines; population-based activities relating to improving health or reducing health care costs, protocol development and related functions that do not include treatment.
- Reviewing health plan performance.
- Premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits.
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
- Performing business planning and development functions, such as conducting cost-management and planning-related analyses relating to management and operations and the development or improvement of methods of payment or coverage policies.
- Performing business management and general administrative activities, including, but not limited to, management activities relating to implementation of and compliance with privacy requirements, customer service, and resolution of internal grievances.

3. For the facilities, "health care operations" means any of the following activities of the department to the extent that the activities are related to covered functions:

- Conducting quality assessment and improvement activities, including evaluation of outcomes and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from these activities; population-based activities relating to improving health or reducing health care costs; protocol development; case management and care coordination; contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.
  - Reviewing the competence or qualifications of health care professionals.
  - Evaluating performance of practitioners, providers and health plans.
  - Conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers.
  - Training of non-health care professionals.
  - Performing accreditation, certification, licensing, or credentialing activities.
  - Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
  - Performing business planning and development functions, such as conducting cost-management and planning-related analyses related to managing and operating the organization,

including formulary development and administration, development or improvement of methods of payment or coverage policies.

- Performing business management and general administrative activities, including, but not limited to, management activities related to implementation of and compliance with the requirements of HIPAA; customer service, which includes the provision of data analyses for policyholders, plan sponsors, or other customers, provided that protected health information is not disclosed to the policyholder, plan sponsor, or customer; resolution of internal grievances; and activities consistent with the applicable requirements of subrule 9.10(29) on creating de-identified health information or a limited data set.

*“Health care provider”* means a provider of services, as defined in Section 1861(u) of the Social Security Act and 42 U.S.C. 1395x(u); a provider of medical or health services, as defined in Section 1861(s) of the Social Security Act and 42 U.S.C. 1395x(s); and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business. In the department, “health care provider” means one of the department’s facilities.

*“Health information”* means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a subject; the provision of health care to a subject; or the past, present, or future payment for the provision of health care to a subject.

*“Health maintenance organization (HMO)”* means a public or private organization licensed as an HMO under the commerce department, insurance division, 191—Chapter 40.

*“Health oversight agency”* means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or organization acting under a grant of authority from or contract with a public agency, that is authorized by law to:

1. Oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance; or
2. Enforce civil rights laws for which health information is relevant.

The term “health oversight agency” includes the employees or agents of the public agency and its contractors or persons or organizations to which the agency has granted authority.

*“Health plan”* means an individual or group plan that provides or pays the cost of medical care, as defined at 45 CFR 160.103 as amended to August 14, 2002. In the department, “health plan” means Medicaid or HAWK-I.

*“HIPAA”* means the Health Insurance Portability and Accountability Act of 1996.

*“Law enforcement official”* means an officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, who is empowered by law to:

1. Investigate or conduct an official inquiry into a potential violation of law; or
2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

*“Legal representative”* is a person recognized by law as standing in the place or representing the interests of another for one or more purposes. For example, guardians, conservators, custodians, attorneys, parents of a minor, and executors, administrators, or next of kin of a deceased person are legal representatives for certain purposes.

*“Mental health information”* means oral, written, or otherwise recorded information which indicates the identity of a person receiving professional services (as defined in Iowa Code section 228.1(8)) and which relates to the diagnosis, course, or treatment of the person’s mental or emotional condition. Mental or emotional conditions include mental illness, mental retardation, degenerative neurological conditions and any other condition identified in professionally recognized diagnostic manuals for mental disorders.

*“Open record”* means a record other than a confidential record.

*“Payment,”* with respect to HIPAA rules about protected health information, has the same definition as that stated in 45 CFR 164.501 as amended to August 14, 2002. In the department, “payment” applies to subjects for whom health care coverage is provided under the Medicaid program or the HAWK-I program. “Payment” has the following meanings for these health plans:

1. For Medicaid, “payment” includes activities undertaken by this health plan to:
  - Determine or fulfill its responsibility for coverage and provision of benefits under the health plan.
  - Obtain or provide reimbursement for the provision of health care.
  - Determine eligibility, including spenddown for the medically needy program or obtaining premiums for the Medicaid for employed people with disabilities program, or coverage, including coordination of benefits or the determination of cost-sharing amounts, and adjudication or subrogation of health benefit claims.
  - Perform risk adjustment of amounts due based on enrollee health status and demographic characteristics.
  - Bill; manage claims; collect; obtain payment under a contract for reinsurance, including stop-loss insurance and excess of loss insurance; and conduct related health care data processing.
  - Review health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.
  - Perform utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services.
2. For the HAWK-I program, “payment” includes activities undertaken by this health plan to:
  - Obtain reimbursement or pay for providing health care services.
  - Obtain premiums or determine or fulfill its responsibility for coverage and providing benefits. Activities include, but are not limited to, determinations of eligibility for coverage, including coordination of benefits or the determination of cost-sharing amounts; billing and collection activities; review of health care services with respect to coverage under a health plan; and utilization review activities.

“*Personally identifiable information*” means information about or pertaining to the subject of a record which identifies the subject and which is contained in a record system. The incidental mention of another person’s name in a subject’s record (e.g., as employer, landlord, or reference) does not constitute personally identifiable information.

“*Personal representative*” means someone designated by another as standing in the other’s place or representing the other’s interests for one or more purposes. The term “personal representative” includes, but is not limited to, a legal representative. For disclosure of protected health information, the definition of “personal representative” is more restrictive, as described at rule 441—9.15(17A,22).

“*Plan sponsor*” has the same definition as that stated in Section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

“*Protected health information*” means information that contains a subject’s medical information, including past, present, or future treatment and payment information. “Protected health information” is a composite of multiple fields that grouped together give detailed accumulative information about a subject’s health. When joined together in an accessible record set, the following three distinct areas of health-care-processing file information constitute protected health information:

1. Information that identifies the subject.
2. Medical information describing condition, treatment, or health care.
3. Health care provider information.

Identification information together with any information from one of the other two categories constitutes protected health information. When the information that identifies the subject is present in the record set, any information that ties health care data to the subject’s identification information constitutes protected health information.

“*Psychotherapy notes*” means notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the subject’s medical record. “Psychotherapy notes” excludes medication prescription and monitoring, counseling session start and stop times, the methods of therapy and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

*“Public health authority”* means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or organization acting under a grant of authority from or contract with a public agency that is responsible for public health matters as part of its official mandate. “Public health authority” includes the employees or agents of the public agency and its contractors or persons or organizations to which it has granted authority.

*“Record”* means the whole or a part of a “public record” as defined in Iowa Code section 22.1, that is owned by or in the physical possession of the department.

*“Record system”* means any group of records under the control of the department from which a record may be retrieved by a personal identifier such as the name of a subject, number, symbol, or other unique identifier assigned to a subject.

*“Required by law”* means a mandate contained in federal law, federal regulation, state law, state administrative rule, case law, or court order that is enforceable in a court of law. For the purposes of this chapter, “required by law” includes statutes or regulations that require the production of information, such as statutes or regulations that require the information if payment is sought under a government program that provides public benefits.

*“Research”* means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

*“Subject”* means the person who is the subject of the record, whether living or deceased.

*“Substance abuse information”* means information which indicates the identity, diagnosis, prognosis, or treatment of any person in an alcohol or drug abuse program.

*“Transaction”* means the electronic transmission of information between two parties to carry out financial or administrative activities related to health care. The term includes the following defined HIPAA standard transactions:

- Health care claims or equivalent encounter information.
- Health care payment and remittance advice.
- Coordination of benefits.
- Health care claim status.
- Enrollment and disenrollment in a health plan.
- Eligibility for a health plan.
- Health plan premium payments.
- Referral certification and authorization.
- Other transactions that the Secretary of Health and Human Services may prescribe by regulation.

*“Treatment,”* with respect to HIPAA rules about protected health information, means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation among health care providers about a patient; and the referral of a patient from one health care provider to another.

*“Use,”* with respect to protected health information, means the sharing, application, utilization, examination, or analysis of the information within an organization that maintains the protected health information.

*“Workforce”* means employees, volunteers, trainees, and other people whose conduct, in the performance of work for the covered entity, is under the direct control of the covered entity, whether or not these people are paid by the covered entity.

**441—9.2(17A,22) Statement of policy.** The purpose of this chapter is to facilitate broad public access to open records. It also seeks to facilitate sound department determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This department is committed to the policies set forth in Iowa Code chapter 22. Department staff shall cooperate with members of the public in implementing the provisions of that chapter.

**441—9.3(17A,22) Requests for access to records.**

**9.3(1) Location of record.** A request for access to a record should be directed to the director or the particular department office where the record is kept.

*a.* If the location of the record is not known by the requester, the request shall be directed to the Office of Policy Analysis, Department of Human Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

*b.* If a request for access to a record is misdirected, department personnel will promptly forward the request to the appropriate person within the department.

**9.3(2) Office hours.** Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays and legal holidays.

**9.3(3) Request for access.** Requests for access to open records may be made in writing, in person, or by telephone. Requests shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail or telephone requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

**9.3(4) Response to requests.** Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing.

The custodian of a record may deny access to the record by members of the public only on the grounds that such a denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court order. Access by members of the public to a confidential record is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 441—9.4(17A,22) and other applicable provisions of law.

**9.3(5) Security of record.** No person may, without permission from the custodian, search or remove any record from department files. Examination and copying of department records shall be supervised by the custodian or a designee of the custodian. Records shall be protected from damage and disorganization.

**9.3(6) Copying.** A reasonable number of copies of an open record may be made in the department office. If photocopy equipment is not available in the department office where an open record is kept, the custodian shall permit its examination in that office and shall arrange to have copies promptly made elsewhere.

**9.3(7) Fees.**

*a. When charged.* The department may charge fees in connection with the examination or copying of records only if the fees are authorized by law. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

*b. Copying and postage costs.* Price schedules for published materials and for photocopies of records supplied by the department shall be prominently posted in department offices. Copies of records may be made by or for members of the public on department photocopy machines or from electronic storage systems at cost as determined and posted in department offices by the custodian. When the mailing of copies of records is requested, the actual costs of such mailing may also be charged to the requester.

*c. Supervisory fee.* An hourly fee may be charged for actual department expenses in supervising the examination and copying of requested records when the supervision time required is in excess of one-half hour. The custodian shall prominently post in department offices the hourly fees to be charged for supervision of records during examination and copying. That hourly fee shall not be in excess of the hourly wage of a department clerical employee who ordinarily would be appropriate and suitable to perform this supervisory function.

*d. Advance deposits.*

(1) When the estimated total fee chargeable under this subrule exceeds \$25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

(2) When a requester has previously failed to pay a fee chargeable under this subrule, the custodian may require advance payment of the full amount of any estimated fee before the custodian processes a new request from that requester.

*e. Summary of health information.* The department may charge a fee for the cost of preparing an explanation or summary of health information as provided in paragraph 9.9(1)“c.” The department and the subject requesting the information shall agree to the amount of any fee imposed before the department prepares the explanation or summary.

**441—9.4(17A,22) Access to confidential records.** Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to one or more members of the public. Other provisions of law authorize or require the custodian to release specified confidential records under certain circumstances or to particular persons. In requesting the custodian to permit the examination and copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 441—9.3(17A,22).

**9.4(1) Proof of identity.** A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

**9.4(2) Requests.** The custodian may require a request to examine and copy a confidential record to be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

**9.4(3) Notice to subject of record and opportunity to obtain injunction.**

*a.* Except as provided in 441—subrule 175.41(2), after receiving a request for access to a confidential record and before releasing the record, the custodian may make reasonable efforts to promptly notify any person:

- (1) Who is a subject of that record,
- (2) Who is identified in that record, and
- (3) Whose address or telephone number is contained in the record.

*b.* To the extent such a delay is practicable and in the public interest, the custodian may give the notified subject a reasonable time to seek an injunction under Iowa Code section 22.8. The custodian shall inform the subject identified in the record of how much time the subject has to seek an injunction before the information will be released.

**9.4(4) Request denied.** When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

- a.* The name and title or position of the custodian responsible for the denial; and
- b.* A citation to the provision of law vesting authority in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to this requester.

**9.4(5) Request granted.** Except as provided in 441—subrule 175.41(2), when the custodian grants a request for access to a confidential record, the custodian shall notify the requester or the person who is to receive the information and include any limits on the examination and copying of the record.

**9.4(6) Records requiring special procedures.** Special procedures are required for access to:

*a.* Child abuse information. Access to child abuse information is obtained according to rules 441—175.41(235A) and 441—175.42(235A).

*b.* Dependent adult abuse information. Access to adult abuse information is governed by rule 441—176.10(235A).

*c.* Quarterly list. Rescinded IAB 10/4/00, effective 12/1/00.

**441—9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations.** The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order, to refuse to disclose that record to members of the public.

**9.5(1) *Persons who may request.*** Any person who would be aggrieved or adversely affected by disclosure of a record and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order, authorizes the custodian to treat the record as a confidential record, may request the custodian to treat that record as a confidential record and to withhold it from public inspection.

**9.5(2) *Request.*** A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the custodian.

*a.* The request must set forth the legal and factual basis justifying such confidential record treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request.

*b.* A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit stating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts.

*c.* Requests to temporarily treat a record as a confidential record shall specify the precise period of time for which that treatment is requested.

*d.* A person filing such a request shall, if possible, provide a copy of the record in question from which those portions for which such confidential record treatment has been requested have been deleted. If the original record is being submitted to the department by the person requesting confidential treatment at the time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are confidential.

**9.5(3) *Failure to request.*** Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted business information to the department does not request that it be withheld from public inspection under Iowa Code sections 22.7(3) and 22.7(6), the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

**9.5(4) *Timing of decision.*** A decision by the custodian with respect to the disclosure of a record to members of the public may be made when a request for its treatment as a confidential record that is not available for public inspection is filed, or when the custodian receives a request for access to the record by a member of the public.

**9.5(5) *Request granted or deferred.*** If a request for such confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

**9.5(6) *Request denied and opportunity to seek injunction.*** If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of that determination and the reasons therefor. On application by the requester, the custodian may engage in a good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, such a record shall not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs

the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

**9.5(7) Rights to request privacy protection for protected health information.** When the subject is requesting a restriction or confidential communication of protected health information, the department shall follow the provisions of this subrule, as applicable, in addition to the provisions of subrules 9.5(1) through 9.5(6).

*a. Restriction of uses and disclosures.*

(1) The subject may request that the department restrict uses or disclosures of the subject's protected health information:

1. To carry out treatment, payment, or health care operations; and
2. To persons involved in the subject's care or for notification purposes as permitted under subrule 9.7(3).

(2) The subject shall submit a request to the department on Form 470-3953, Request to Restrict Use or Disclosure of Health Information. If applicable, the subject shall provide verification that it is reasonable to anticipate the use or disclosure will endanger the subject.

(3) The department is not required to agree to a restriction. The department shall deny any restriction when the restriction would adversely affect the quality of the subject's care or services, the restriction would limit or prevent the department from making or obtaining payment for services, or federal or state law requires the use or disclosure. The department shall approve the request for restriction only when the use or disclosure would endanger the subject and none of the above reasons for denial apply.

(4) The department shall send the subject a written notice to accept or deny the restriction.

(5) If the department agrees to a restriction, it may not use or disclose protected health information in violation of the restriction. **EXCEPTION:** The department may use restricted protected health information or disclose the information to a health care provider when needed for the emergency treatment of the subject who requested the restriction. If restricted protected health information is disclosed to a health care provider for emergency treatment, the department shall request that the health care provider not further use or disclose the information.

(6) A restriction agreed to by the department under paragraph 9.5(7) "a" shall not prevent disclosures of protected health information to the Secretary of Health and Human Services to investigate or determine the department's compliance with federal HIPAA regulations. Also, a restriction shall not prevent uses or disclosures permitted or required for the categories listed in subparagraphs 9.14(5) "a"(1) through (11).

(7) The department may terminate its agreement to a restriction in writing if:

1. The subject agrees to or requests the termination in writing;
2. The subject orally agrees to the termination and the oral agreement is documented; or
3. The department informs the subject that it is ending its agreement to a restriction for protected health information created or received after it has so informed the subject.

*b. Confidential communications.* Subjects may ask to receive communications of protected health information by alternative means or at alternative locations. The department shall accommodate reasonable requests. For Medicaid and HAWK-I, the subject is required to clearly indicate the reason for requesting the confidential communication. Facilities shall not require the subject to explain the basis for the request as a condition of providing confidential communications.

(1) The subject shall request a confidential communication from the department using Form 470-3947, Request to Change How Health Information Is Provided.

(2) The department may require the subject to provide:

1. When appropriate, information as to how payment, if any, will be handled; and
2. An alternative address or other method of contact.

**441—9.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records.**

**9.6(1) All programs.** Except as otherwise provided by law, a subject may file a request with the custodian to review, and to have a written statement of additions, dissents, or objections entered into, a record containing personally identifiable information pertaining to that subject. However, the subject is not authorized to alter the original copy of the record or to expand the official record of any department proceeding.

*a.* The subject shall send the request to review such a record or the written statement of additions, dissents, or objections to the custodian or to the office of policy analysis.

*b.* The request to review such a record or the written statement of additions, dissents, or objections must be dated and signed by the subject, and shall include the current address and telephone number of the subject or the subject's representative.

**9.6(2) Additional procedures for protected health information.**

*a. Right to amend.* A subject may request that the department amend protected health information or a record about the subject in a designated record set for as long as the protected health information is maintained in the designated record set. A subject shall submit a request to the department using Form 470-3950, Request to Amend Health Information. The subject shall provide a reason to support the requested amendment.

*b. Timely action.*

(1) The department shall act on a subject's request for an amendment no later than 60 days after receipt of the request.

(2) If the department is unable to act on the amendment within 60 days, the department may extend the due date one time, for a period not to exceed 30 days. In order to extend the due date, the department shall provide the subject with a written statement of the reasons for the delay and the date by which the department will complete its action on the request. The department shall provide this written statement within the 60-day period after receipt of the request.

*c. Action on amendment.* If the department grants the requested amendment, in whole or in part, the department shall comply with the following requirements.

(1) The department shall timely inform the subject that the amendment is accepted. The subject shall identify relevant persons with whom the amendment needs to be shared and agree to have the department share the amendment with these persons.

(2) The department shall make the appropriate amendment to the protected health information or record by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

(3) The department shall make reasonable efforts to inform and provide the amendment to:

1. Persons identified by the subject as having received protected health information about the subject and as needing the amendment; and

2. Persons, including business associates, that the department knows have the subject's protected health information and that may have relied, or could foreseeably rely, on the information to the detriment of the subject.

*d. Denial of amendment.* The department may deny a subject's request for amendment, if the department determines that the protected health information or record that is the subject of the request:

(1) Was not created by the department, unless the subject provides a reasonable basis for the department to find that the originator of the protected health information is no longer available to act on the requested amendment;

(2) Is not part of the designated record set;

(3) Would not be available for inspection under rule 441—9.9(17A,22); or

(4) Is accurate and complete.

*e. Action on denial of amendment.* If the department denies the requested amendment, in whole or in part, the department shall provide the subject with a timely, written denial.

(1) The subject may submit to the department a written statement of disagreement with the denial of all or part of a requested amendment and the basis of the disagreement, in accordance with 45 CFR

164.526 as amended to August 14, 2002. The subject shall submit the statement of disagreement by filing an appeal request under subrule 9.14(7). The appeal request constitutes the statement of disagreement.

(2) The department shall prepare a written rebuttal to the subject's statement of disagreement, in accordance with 45 CFR 164.526 as amended to August 14, 2002. The appeal decision constitutes the rebuttal statement. The department shall provide a copy of the appeal decision to the subject who submitted the appeal request.

*f. Record keeping of disputed amendments.* The department shall, as appropriate, identify the record or protected health information in the designated record set that is the subject of the disputed amendment. The department shall append or otherwise link the subject's request for an amendment, the department's denial of the request, and the subject's appeal and the final decision, if any, to the designated record set.

*g. Future disclosures regarding disputed amendments.*

(1) If an appeal has been submitted by the subject, the department shall include the material appended in accordance with paragraph 9.6(2) "f" or, at the election of the department, an accurate summary of the information, with any subsequent disclosure of the protected health information to which the disagreement relates.

(2) If the subject has not submitted an appeal, the department shall include the subject's request for amendment and its denial, or an accurate summary of the information, with any subsequent disclosure of the protected health information only if the subject has requested this action.

(3) When a subsequent disclosure is made using a standard transaction that does not permit the additional material to be included with the disclosure, the department may separately transmit the material required by subparagraph 9.6(2) "g"(1) or (2), as applicable, to the recipient of the standard transaction.

*h. Actions on notices of amendment.* When the department is informed by another covered entity of an amendment to a subject's protected health information, the department shall amend the protected health information in designated record sets as provided by subparagraph 9.6(2) "c"(2).

**441—9.7(17A,22,228) Consent to disclosure by the subject of a confidential record.** To the extent permitted by any applicable provision of law, the subject of a confidential record may have a copy of the portion of that record concerning the subject disclosed to a third party. A request for such a disclosure must be in writing and must identify the particular record or records to be disclosed, the particular person or class of persons to whom the record may be disclosed, and the time period during which the record may be disclosed. The subject of the record and, where applicable, the person to whom the record is to be disclosed may be required to provide proof of identity.

No confidential information about clients of the department shall be released without the client's consent, except as provided in rule 441—9.10(17A,22). Release of information includes:

1. Granting access to or allowing the copying of a record,
2. Providing information either in writing or orally, or
3. Acknowledging information to be true or false.

**9.7(1) Forms.**

*a. General.* Department staff shall use Form 470-2115, Authorization for the Department to Release Information, for releases by the subject that do not involve health information requiring use of the authorization form described in paragraph 9.7(1) "c."

*b. Obtaining information from a third party.* The department is required to obtain information to establish eligibility, determine the amount of assistance, and provide services. Requests to third parties for this information involve release of confidential identifying information about clients. Except as provided in rule 441—9.9(17A,22), the department may make these requests only when the client has authorized the release on one of the following forms.

- (1) Form 470-0461, Authorization for Release of Information.
- (2) Form 470-1630, Household Member Questionnaire.
- (3) Form 470-1631, Bank or Credit Union Information.
- (4) Form 470-4670, Addendum for Application and Review Forms for Release of Information.

- (5) Form 470-1638, Request for School Verification.
- (6) Form 470-2844, Employer's Statement of Earnings.
- (7) Form 470-1640, Verification of Educational Financial Aid.
- (8) Form 470-3742, Financial Institution Verification.
- (9) Form 470-3951, Authorization to Obtain or Release Health Care Information.

*c. Health information.*

(1) When consent or authorization for use or disclosure of health information is required, facilities and department staff responding to third-party requests for health information shall use Form 470-3951, Authorization to Obtain or Release Health Care Information, or a form from another source that meets HIPAA requirements.

The department shall not require a subject to sign a HIPAA authorization form as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. The department as a health care provider may require a subject to sign a HIPAA authorization form for the use or disclosure of protected health information for research, as a condition of the subject's receiving research-related treatment.

A subject may revoke a HIPAA authorization provided under subparagraph 9.7(1) "c"(1) at any time, provided that the revocation is in writing using Form 470-3949, Request to End an Authorization, except to the extent that the department has taken action in reliance thereon.

(2) Except as provided in subparagraph 9.7(1) "c"(1), department staff shall release mental health or substance abuse information only with authorization on Form 470-0429, Consent to Obtain and Release Information, or a form from another source that meets requirements of law.

*d. Photographs and recordings.* The department uses Form 470-0060, Authorization to Take and Use Photographs, and Form 470-0064, Authorization to Take and Use Photographs of Minor or Ward, for permission to use photographs in department publications. The department shall obtain authorization from the subject or person responsible for the subject (such as a guardian, custodian, or personal representative) before taking photographs or making any type of recording for any purpose other than those specifically allowed by law or for internal use within an institution.

*e. Veteran's Home.* Rescinded IAB 10/29/03, effective 11/1/03.

**9.7(2) Exceptions to use of forms.**

*a. Counsel.* Appearance of counsel before the department on behalf of the subject of a confidential record is deemed to constitute consent for the department to disclose records about the subject to the subject's attorney.

*b. Public official.* A letter from the subject to a public official which seeks the official's intervention on behalf of the subject in a matter that involves the department shall be treated as an authorization to release information. The department shall release sufficient information about the subject to the official to resolve the matter.

*c. Medical emergency.* Department staff may authorize release of confidential information to medical personnel in a medical emergency if the subject is unable to give or withhold consent. As soon as possible after the release of information, the subject shall be advised of the release.

*d. Abuse information.* Consent to release information is not required to gather information for investigations of child abuse or dependent adult abuse.

**9.7(3) Opportunity for subject to agree or object.** This subrule describes when the department may use or disclose protected health information, without a written authorization, to persons involved in the subject's care and for notification purposes. However, the department shall give the subject an opportunity to agree or object, unless this requirement is waived as specified in paragraph 9.7(3) "e."

*a. Involvement in the subject's care.* The department may disclose protected health information that is directly relevant either to a subject's care or to payment related to the subject's care, provided payment is relevant to the person's involvement in the subject's care. The person involved must be:

- (1) A family member;
- (2) Another relative;
- (3) A close personal friend of the subject; or
- (4) Any other person identified by the subject.

*b. Notification purposes.* The department may use or disclose protected health information to notify, or assist in notifying, identifying or locating a family member, a personal representative of the subject, or another person responsible for the care of the subject of the subject's location, general condition or death. For disaster relief purposes, the use or disclosure shall be in accordance with paragraph 9.7(3) "f."

*c. Uses and disclosures with the subject present.* If the subject is present for, or available before, a use or disclosure permitted by this subrule and has the capacity to make health care decisions, the department may use or disclose the protected health information if the department:

- (1) Obtains the subject's agreement;
- (2) Provides the subject with the opportunity to object to the disclosure, and the subject does not express an objection; or
- (3) Reasonably infers from the circumstances, based on the exercise of professional judgment, that the subject does not object to the disclosure.

*d. Informing the subject.* The department may orally inform the subject of and obtain the subject's oral agreement or objection to a use or disclosure permitted by this subrule.

*e. Limited uses and disclosures when the subject is not present.* When the subject is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the subject's incapacity or an emergency circumstance, the department may, in the exercise of professional judgment, determine that disclosure is in the best interest of the subject.

(1) When the department determines that disclosure is in the subject's best interest, the department may disclose only the protected health information that is directly relevant to the person's involvement with the subject's health care.

(2) The department may use professional judgment and its experience with common practice to make reasonable inferences of the subject's best interest in allowing a person to act on behalf of the subject to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

*f. For disaster relief purposes.* The department may use protected health information or disclose protected health information to a public or private organization authorized by law or by its charter to assist in disaster relief efforts for the purpose of coordinating with these organizations the uses or disclosures permitted by paragraph 9.7(3) "b." The requirements in paragraphs 9.7(3) "c" and "d" apply to these uses and disclosures to the extent that the department, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

[ARC 0420C, IAB 10/31/12, effective 1/1/13]

**441—9.8(17A,22) Notice to suppliers of information.** When the department requests a person to supply information about that person, the department shall notify the person of how the information will be used, which persons outside the department 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 information requested.

**9.8(1)** 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.

**9.8(2)** The notice shall generally be given at the first contact with the department and need not be repeated. Where appropriate, the notice may be given to a person's legal or personal representative. Notice may be withheld in an emergency or where it would compromise the purpose of a department investigation.

**9.8(3)** In general, the department requests information to determine eligibility and benefit levels for assistance, to provide appropriate services or treatment, and to perform regulatory and administrative functions. Information is routinely shared outside the department when required by rules or law. Consequences of failure to provide information include ineligibility for public assistance, denial of licensure or regulatory approval, or inadequate service provision.

**441—9.9(17A,22) Release to subject.****9.9(1) Access by subjects to protected health information.**

*a. Right of access.* Except as otherwise provided in paragraphs 9.9(1) “f” and “g,” a subject has a right of access to inspect or to obtain a copy of the protected health information about the subject that is maintained in a designated record set. Subjects shall submit all requests for access to the department using Form 470-3952, Request for Access to Health Information.

If the department does not maintain the protected health information that is the topic of the subject’s request for access, and the department knows where the requested information is maintained, the department shall inform the subject where to direct the request for access.

*b. Timely action.*

(1) The department shall act on a request for access no later than 30 days after receipt of the request unless the protected health information is not maintained or accessible to the department on site.

(2) If the requested information is not maintained or accessible to the department on site, the department shall take action no later than 60 days from the receipt of the request.

(3) If the department is unable to act within 30 days or 60 days as appropriate, the department may extend the time for the action by no more than 30 days. Within the applicable time limit, the department shall provide the subject with a written statement of the reasons for the delay and the date by which the department will complete its action on the request. The department shall have only one extension of time for action on a request for access.

*c. Action on providing access.* If the department grants the request, in whole or in part, the department shall inform the subject that the request is accepted and shall provide the access requested. Access includes inspecting the protected health information about the subject in designated record sets, obtaining a copy of the information, or both. If the same protected health information that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the department need only produce the protected health information once in response to a request for access.

(1) The department shall provide the subject with access to the protected health information in the form or format requested by the subject, if the requested format is readily producible. If the requested format is not readily producible, the department shall provide the information in a readable hard-copy form or other format as agreed to by the department and the subject.

(2) The department may provide the subject with a summary of the protected health information requested instead of providing access to the protected health information. The department may provide an explanation of the protected health information to which access has been provided. The subject must agree in advance to a summary or explanation and to any fees imposed by the department for the summary or explanation.

*d. Time and manner of access.* The department shall provide the access as requested by the subject in a timely manner as described in paragraph 9.9(1) “b.” The department shall arrange with the subject for a time and place to inspect or obtain a copy of the protected health information that is convenient for both the subject and the department, or shall mail the copy of the protected health information at the subject’s request. The department may discuss the scope, format, and other aspects of the request for access with the subject as necessary to facilitate the timely provision of access.

*e. Fees for access.* If the subject requests a copy of the protected health information or agrees to a summary or explanation of the information, the department may impose a reasonable, cost-based fee, as set forth in subrule 9.3(7).

*f. Mandatory reasons for denial of access.* The department shall deny a subject access to protected health information when the requested information is:

(1) Psychotherapy notes;

(2) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or

(3) Protected health information maintained by the department that is:

1. Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. Section 263a, to the extent the provision of access to the subject would be prohibited by law; or

2. Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

*g. Optional reasons for denial of access.* The department may deny a subject access in the following circumstances.

(1) The department may temporarily suspend a subject's access to protected health information created or obtained by a covered health care provider in the course of research that includes treatment. The subject must have agreed to the denial of access when consenting to participate in the research that includes treatment. The suspension may last for as long as the research is in progress. The department shall inform the subject that the right of access will be reinstated upon completion of the research.

(2) The department may deny a subject's access to protected health information that is contained in records that are subject to the Privacy Act, 5 U.S.C. Section 552a, if the denial of access under the Privacy Act would meet the requirements of that law.

(3) The department may deny a subject's access if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

(4) State or federal law prohibits a subject's access to protected health information, such as the state law limitations described in subrule 9.9(2).

(5) The department may deny a subject access, provided that the subject is given a right to have the denials reviewed as required by paragraph 9.9(1)"i," in the following circumstances:

1. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the subject or another person;

2. The protected health information makes reference to another person (unless the other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to the other person; or

3. The request for access is made by the subject's personal representative, subject to the more restrictive definition of personal representative for protected health information, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to the personal representative is reasonably likely to cause substantial harm to the subject or another person.

*h. Action on denial of access.* If the department denies access, in whole or in part, to protected health information, the department shall comply with the following requirements.

(1) The department shall, to the extent possible, give the subject access to any other protected health information requested, after excluding the protected health information to which the department has a reason to deny access.

(2) The department shall provide a timely, written denial to the subject, in accordance with paragraph 9.9(1)"b."

*i. Review of denial of access.* If access is denied for a reason permitted under subparagraph 9.9(1)"g"(5), a subject may submit a written request for a review of a denial. If the subject requests a review, the department shall promptly refer the request to a licensed health care professional who is designated by the department to act as a reviewing official and who did not participate in the original decision to deny.

(1) The designated reviewing official shall determine, within 30 days, whether or not to deny the access requested based on the standards in subparagraph 9.9(1)"g"(5).

(2) The department shall promptly provide written notice to the subject of the determination made by the designated reviewing official and shall take other action as required to carry out the designated reviewing official's determination.

**9.9(2) Access by subjects to other confidential information.** The department shall release confidential records to the subject of the record. However, when a record has multiple subjects with interest in the confidentiality of the record, the department may take reasonable steps to protect confidential information relating to another subject. The department need not release the following records to the subject:

- a.* Records need not be disclosed to the subject when they are the work product of an attorney or are otherwise privileged.
- b.* The identity of a person reporting suspected abuse to the department need not be disclosed to the subject. (See 441—subrule 175.41(2) and Iowa Code section 235A.19.)
- c.* The identity of a person providing information to the department need not be disclosed directly or indirectly to the subject of the information when that information is authorized to be held confidential pursuant to Iowa Code section 22.7(18).
- d.* Peace officers' investigative reports may be withheld from the subject, pursuant to Iowa Code section 22.7(5).
- e.* The department may withhold disclosure of confidential information when the department has reason to believe that disclosure of the information would cause substantial and irreparable harm and would not be in the public interest. The department may withhold disclosure to seek an injunction to restrain examination of the record according to procedures in Iowa Code section 22.8 or to notify the person who would be harmed to allow that person to seek an injunction.
- f.* The department may withhold information as otherwise authorized by law.

**441—9.10(17A,22) Use and disclosure without consent of the subject.** Open records are routinely disclosed without the consent of the subject. To the extent allowed by law, the department may also use and disclose confidential information without the consent of the subject or the subject's representative.

**9.10(1) Internal use.** Confidential information may be disclosed to employees and agents of the department as needed for the performance of their duties. The custodian of the record shall determine what constitutes legitimate need to use confidential records.

People affected by this rule include:

1. County-paid staff, field work students, and volunteers working under the direction of the department.
2. Council and commission members.
3. Policy review and advisory committees.
4. Consultants to the department.

**9.10(2) Audits and health oversight activities.**

*a. Audits.* Information concerning program expenditures and client eligibility is released to staff of the state executive and legislative branches who are responsible for ensuring that public funds have been managed correctly. Information is also released to auditors from federal agencies when those agencies provide program funds.

*b. Health oversight activities.* The department shall disclose protected health information to the Secretary of Health and Human Services to investigate or determine the department's compliance with federal HIPAA regulations.

(1) Except as specified in paragraph 9.10(2)“c,” the department may also use protected health information, or disclose it to a health oversight agency, for other health oversight activities authorized by law. Health oversight activities include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

1. The health care system;
2. Government benefits programs for which protected health information is relevant to client eligibility;
3. Organizations subject to government regulatory programs for which protected health information is necessary for determining compliance with program standards; or
4. Organizations subject to civil rights laws for which protected health information is necessary for determining compliance.

(2) If a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation shall be considered a health oversight activity for purposes of subrule 9.10(2).

*c. Exception to health oversight activities.* For the purpose of the disclosures permitted by paragraph 9.10(2) “b,” a health oversight activity shall not include an investigation or other activity in which the subject is also the subject of the investigation or activity, unless the investigation or other activity directly relates to:

- (1) The receipt of health care;
- (2) A claim for public health benefits; or
- (3) Qualification for or receipt of public benefits or services, when a patient’s health is integral to the claim for public benefits or services.

**9.10(3) Program review.** Information concerning client eligibility and benefits is released to state or federal officials responsible for determining whether the department is operating a program lawfully. These officials include the citizens’ aide office under Iowa Code section 2C.9, the auditor of state under Iowa Code section 11.2, the Office of Inspector General in the federal Department of Health and Human Services, and the Centers for Medicare and Medicaid Services.

**9.10(4) Contracts and agreements with agencies and persons.**

*a.* The department may enter into contracts or agreements with public or private agencies, such as the department of inspections and appeals, and business associates, such as, but not limited to, the Iowa Medicaid enterprise units, in order to carry out the department’s official duties. Information necessary to carry out these duties may be shared with these agencies. The department may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the department obtains satisfactory assurance that the business associate will appropriately safeguard the information.

*b.* The department may enter into agreements to share information with agencies administering federal or federally assisted programs which provide assistance or services directly to persons on the basis of need. Only information collected in the family investment program, the child care assistance program, the food assistance program, the refugee resettlement program, or the child support recovery program may be shared under these agreements.

*c.* To meet federal income and eligibility verification requirements, the department has entered into agreements with the department of workforce development, the United States Internal Revenue Service, and the United States Social Security Administration.

The department obtains information regarding persons whose income or resources are considered in determining eligibility and the amount of benefits for the family investment program, refugee cash assistance, child care assistance, food assistance, Medicaid, state supplementary assistance and foster care. Identifying information regarding clients of these programs is released to these agencies. The information received may be used for eligibility and benefit determinations.

*d.* To meet federal requirements under the Immigration Reform and Control Act of 1986 (IRCA) relating to the Systematic Alien Verification for Entitlements (SAVE) program, the department has entered into an agreement with the Bureau of Citizenship and Immigration Service (BCIS). Under the agreement, the department exchanges information necessary to verify alien status for the purpose of determining eligibility and the amount of benefits for the family investment program, refugee cash assistance, food assistance, Medicaid, state supplementary assistance and foster care assistance. Identifying information regarding these subjects is released to the BCIS. The information received may be used for eligibility and benefit determinations.

*e.* The department has entered into an agreement with the department of workforce development to provide services to family investment program clients participating in the PROMISE JOBS program as described at 441—Chapter 93. Information necessary to carry out these duties shall be shared with the department of workforce development, as well as with its subcontractors.

The department has entered into an agreement with the department of human rights to provide services to family investment program clients participating in the family development and self-sufficiency program as described at 441—Chapter 165. Information necessary to carry out these duties shall be shared with the department of human rights, as well as with that agency’s subcontractors.

*f.* State legislation requires that all emergency assistance households apply for and accept benefits for which they may qualify from the energy assistance, county general relief and veteran’s

affairs programs before approval for emergency assistance. To meet this requirement, the department may enter into agreements with the agencies that administer these programs under which they may provide services to emergency assistance households as described at 441—Chapter 58. Information necessary to carry out these duties shall be shared with these agencies.

*g.* The department has entered into an agreement with the department of education, vocational rehabilitation, disability determination services, to assist with Medicaid disability determinations.

*h.* The department has entered into an agreement with the department of education to share information that assists both schools and department clients in carrying out the annual verification process required by the United States Department of Agriculture, Food and Nutrition Service. That federal agency requires the department of education and local schools to verify eligibility of a percentage of the households approved for free-meal benefits under the school lunch program.

When a department office receives a written request from the local school, the department office responds in writing with the current family investment program and food assistance program status of each recipient of free meals listed in the request. Other client-specific information is made available only with written authorization from the client.

**9.10(5) *Release for judicial and administrative proceedings.*** Information is released to the court as required in Iowa Code sections 125.80, 125.84, 125.86, 229.8, 229.10, 229.13, 229.14, 229.15, 229.22, 232.48, 232.49, 232.52, 232.71B, 232.81, 232.97, 232.98, 232.102, 232.111, 232.117 and 235B.3.

*a.* The department may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the department discloses only the protected health information expressly authorized by the order and the court makes the order knowing that the information is confidential.

*b.* When a court subpoenas information that the department is prohibited from releasing, the department shall advise the court of the statutory and regulatory provisions against disclosure of the information and shall disclose the information only on order of the court.

**9.10(6) *Fraud.*** Information concerning suspected fraud or misrepresentation to obtain department services or assistance is disclosed to the department of inspections and appeals and to law enforcement authorities.

**9.10(7) *Service referrals.*** Information concerning clients may be shared with purchase of service providers under contract to the department.

*a.* Information concerning the client's circumstances and need for service is shared with prospective providers to obtain placement for the client. If the client is not accepted for service, all written information released to the provider shall be returned to the department.

*b.* When the information needed by the provider is mental health information or substance abuse information, the subject's specific consent is required in subrule 9.3(4).

**9.10(8) *Medicaid billing.*** Only the following information shall be released to bona fide providers of medical services in the event that the provider is unable to obtain it from the subject and is unable to complete the Medicaid claim form without it:

*a.* Patient identification number.

*b.* Health coverage code as reflected on the subject's medical card.

*c.* The subject's date of birth.

*d.* The subject's eligibility status for the month that the service was provided.

*e.* The amount of spenddown.

*f.* The bills used to meet spenddown.

**9.10(9) *County billing.*** Information necessary for billing is released to county governments that pay part of the cost of care for intermediate care facility services for the mentally retarded under 441—subrule 82.14(2) or Medicaid waiver services under rule 441—83.70(249A) or 441—83.90(249A). This information includes client names, identifying numbers, provider names, number of days of care, amount of client payment, and amount of payment due.

**9.10(10) *Child support recovery.*** The child support recovery unit has access to information from most department records for the purpose of establishing and enforcing support obligations. Information about absent parents and recipients of child support services is released according to the provisions of

Iowa Code chapters 234, 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, 252K, 598, 600B, and any other support chapter. Information is also released to consumer reporting agencies as specified in rule 441—95.12(252B).

**9.10(11) *Refugee resettlement program.*** Contacts with both sponsor and resettlement agencies are made as a part of the verification process to determine eligibility or the amount of assistance. When a refugee applies for cash or Medicaid, the refugee's name, address, and telephone number are given to the refugee's local resettlement agency.

**9.10(12) *Abuse investigation.*** The central abuse registry disseminates child abuse information and dependent adult abuse information as provided in Iowa Code sections 235A.15 and 235B.7, respectively. Reports of child abuse and dependent adult abuse investigations are submitted to the county attorney as required in Iowa Code sections 232.71B and 235B.3. Results of the investigation of a report by a mandatory reporter are communicated to the reporter as required in Iowa Code sections 235A.17(2) and 235A.15(2) "b"(5).

**9.10(13) *Foster care.*** Information concerning a child's need for foster care is shared with foster care review committees or foster care review boards and persons named in the case permanency plan.

**9.10(14) *Adoption.*** Adoptive home studies completed on families who wish to adopt a child are released to licensed child-placing agencies, to the United States Immigration and Naturalization Service, and to adoption exchanges. Information is released from adoption records as provided in Iowa Code sections 600.16 and 600.24.

**9.10(15) *Disclosures to law enforcement.***

*a. Disclosures by workforce members who are crime victims.* The department is not considered to have violated the requirements of this chapter if a member of its workforce who is the victim of a criminal act discloses confidential information to a law enforcement official, provided that:

(1) The confidential information disclosed is about the suspected perpetrator of the criminal act and intended for identification and location purposes; and

(2) The confidential information disclosed is limited to the following information:

1. Name and address.

2. Date and place of birth.

3. Social security number.

4. ABO blood type and Rh factor.

5. Type of injury.

6. Date and time of treatment.

7. Date and time of death, if applicable.

8. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

*b. Crime on premises.* The department may disclose to a law enforcement official protected health information that the department believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the department.

*c. Decedents.* The department may disclose protected health information to a law enforcement official about a subject who has died when the death resulted from child abuse or neglect or the death occurred in a department facility.

*d. Other.* The department may disclose confidential information to a law enforcement official when otherwise required or allowed by this chapter, such as disclosures about victims of child abuse or neglect; disclosures to avert a threat to health or safety, or to report suspected fraud; disclosures required by due process of law, such as disclosures for judicial and administrative proceedings; or other disclosures required by law.

**9.10(16) *Response to law enforcement.*** The address of a current recipient of family investment program benefits may be released upon request to a federal, state or local law enforcement officer if the officer provides the name of the recipient, and the officer demonstrates that:

*a.* The recipient is a fugitive felon who is fleeing prosecution, custody or confinement after conviction under state or federal law, or who is a probation or parole violator under state or federal law, or

b. The recipient has information that is necessary for the officer to conduct the officer's official duties, and

c. The location or apprehension of the recipient is within the officer's official duties.

**9.10(17) Research.** Information that does not identify individual clients may be disclosed for research purposes with the consent of the division administrator responsible for the records. The division administrator shall investigate the credentials of the researcher.

a. Mental health information may be disclosed for purposes of scientific research as provided in Iowa Code section 228.5, subsection 3, and section 229.25. Requests to do research involving records of a department facility shall be approved by the designated authority.

b. Abuse registry information may be disclosed for research purposes as provided in rules 441—175.42(235A) and 441—176.11(235B) and authorized by Iowa Code sections 235A.15(2) "e"(1) and 235B.6(2) "e"(1).

c. For research relating to protected health information, the researcher shall provide the department with information about the nature of the research, the protocol, the type of information being requested, and any other relevant information that is available concerning the request. If the researcher feels that contact with the subject is needed, the researcher shall demonstrate to the department that the research cannot be conducted without contact with the subject. The researcher shall pay for the costs of obtaining authorizations needed to contact the subjects and for the cost of files and preparation needed for the research.

**9.10(18) Threat to health or safety.**

a. All programs. A client's name, identification, location, and details of a client's threatened or actual harm to department staff or property may be reported to law enforcement officials. Other information regarding the client's relationship to the department shall not be released.

When a department staff person believes a client intends to harm someone, the staff person may warn the intended victim or police or both. Only the name, identification, and location of the client and the details of the client's plan of harm shall be disclosed.

b. Protected health information. The department may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the department, in good faith, believes the use or disclosure:

(1) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(2) Is necessary for law enforcement purposes as described in this chapter.

c. When the department uses or discloses protected health information pursuant to paragraph 9.10(18) "b," the department is considered to have acted in good faith if the action is based on the department's actual knowledge or on a credible representation by a person with apparent knowledge or authority.

**9.10(19) Required by law.**

a. Information is shared with other agencies without a contract or written agreement when federal law or regulations require it.

b. The department may use or disclose protected health information to the extent that use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law.

c. State law shall preempt rules in this chapter about protected health information when any one of the following conditions exists:

(1) Exception granted by Secretary of Health and Human Services. A determination is made by the Secretary of Health and Human Services under 45 CFR 160.204 as amended to August 14, 2002, that the provision of state law:

1. Is necessary:

- To prevent fraud and abuse related to the provision of or payment for health care;
- To ensure appropriate state regulation of insurance and health plans to the extent expressly authorized by statute or regulation;

- For state reporting on health care delivery or costs; or
- For purposes of serving a compelling need related to public health, safety, or welfare, and, if a requirement under this chapter is at issue, the Secretary of Health and Human Services determines that the intrusion into privacy is warranted when balanced against the need to be served; or

2. Has as its principal purpose, the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances, as defined in 21 U.S.C. 802, or that is deemed a controlled substance by state law.

(2) State law more stringent. The provision of state law relates to the privacy of protected health information and is more stringent than a requirement of this chapter, within the meaning of “more stringent” found at 45 CFR 160.202 as amended to August 14, 2002.

(3) Reporting requirements. The provision of state law, including state procedures established under the law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention.

(4) Requirements related to audits, monitoring, evaluation, licensing, and certification. The provision of state law requires a health plan to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities and persons.

**9.10(20) School attendance.** Rescinded IAB 7/7/04, effective 7/1/04.

**9.10(21) Treatment, payment, or health care operations.**

*a.* The department may use or disclose protected health information for treatment, payment, or health care operations, as described in this paragraph, except for psychotherapy notes, which are subject to the limits described in paragraph 9.10(21) “*b.*” The use or disclosure shall be consistent with other applicable requirements of this chapter.

(1) The department may use or disclose protected health information for its own treatment, payment, or health care operations.

(2) The department may disclose protected health information for treatment activities of a health care provider.

(3) The department may disclose protected health information to another covered entity or a health care provider for the payment activities of the person or organization that receives the information.

(4) The department may disclose protected health information to another covered entity for health care operations activities of the covered entity that receives the information, if each covered entity either has or had a relationship with the person who is the subject of the protected health information being requested, the protected health information pertains to the relationship, and the disclosure is:

1. For a purpose listed in numbered paragraph “1” or “2” of the definition of health care operations in 45 CFR 164.501 as amended to August 14, 2002; or

2. For the purpose of health care fraud and abuse detection or compliance.

*b.* The department may use or disclose psychotherapy notes without an authorization for any one of the following reasons:

(1) To carry out the following treatment, payment, or health care operations:

1. Use by the originator of the psychotherapy notes for treatment.

2. Use or disclosure by the department for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

3. Use or disclosure by the department to defend itself in a legal action or other proceeding brought by the subject.

(2) When required by the Secretary of Health and Human Services to investigate or determine the department’s compliance with federal HIPAA regulations.

(3) For health oversight activities, as described at subrule 9.10(2), with respect to the oversight of the originator of the psychotherapy notes.

(4) When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public as described at subrule 9.10(18).

(5) When required by law as described at subrule 9.10(19).

(6) To disclose protected health information in the designated record set to a coroner or medical examiner as described at subrule 9.10(24).

**9.10(22) *Public health activities.*** The department may disclose protected health information for the public health activities and purposes described in this subrule. This disclosure is in addition to any other disclosure to a public health authority allowed by this chapter, such as a disclosure to report child abuse or neglect. For the purposes of this subrule, a public health authority includes state and local health departments, the Food and Drug Administration (FDA), and the Centers for Disease Control and Prevention.

*a.* The department may disclose protected health information to a public health authority that is authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

(1) The information that may be disclosed includes, but is not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.

(2) At the direction of a public health authority, the department may also report this information to an official of a foreign government agency that is acting in collaboration with a public health authority.

*b.* The department may disclose protected health information to a person or organization that is subject to the jurisdiction of the FDA for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity for which that person or organization has responsibility. These purposes include:

(1) To collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product).

(2) To track FDA-regulated products.

(3) To enable product recalls, repairs, or replacement, or lookback (including locating and notifying subjects who have received products that have been recalled, withdrawn, or are the subject of lookback).

(4) To conduct postmarketing surveillance.

*c.* The department may disclose protected health information to a person who is at risk of contracting or spreading a disease or condition. The disclosure must be necessary to carry out public health interventions or investigations or to notify a person that the person has been exposed to a communicable disease to prevent or control the spread of the disease.

**9.10(23) *Victims of domestic violence.*** The department shall disclose confidential information about an individual whom the department reasonably believes to be a victim of domestic violence when required by state law.

**9.10(24) *Disclosures to coroners, medical examiners, and funeral directors.***

*a. Coroners and medical examiners.* The department may disclose protected health information about a subject that is contained in the designated record set to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

*b. Funeral directors.* The department may disclose protected health information about a subject that is contained in the designated record set to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the department may disclose the protected health information before, and in reasonable anticipation of, the subject's death.

**9.10(25) *Disclosures for cadaveric organ, eye or tissue donation purposes.*** The department may disclose protected health information about a subject that is contained in the designated record set to organ procurement organizations or other organizations engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation. The department shall make a disclosure only when the disclosure has been approved by the deceased subject's authorized legal representative and there is evidence that the decedent had given approval for organ, eye, or tissue donation procedures before the decedent's death.

**9.10(26) *Specialized government functions.*** Protected health information may be shared under the circumstances described at 45 CFR 164.512, paragraph "k," as amended to August 14, 2002, if

otherwise allowable under state law, such as sharing protected health information with the Social Security Administration in determining Medicaid eligibility for supplemental security income applicants and recipients.

**9.10(27) Whistle blowers.** The department is not considered to have violated the requirements of this chapter when a member of its workforce or a business associate discloses protected health information, provided that:

*a.* The workforce member or business associate has a good-faith belief that the department or a business associate has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or has provided care, services, or conditions that potentially endanger one or more patients, workers, or the public; and

*b.* The disclosure is made to one of the following:

(1) A health oversight agency or public health authority authorized by law to investigate or oversee conduct or conditions for the purpose of reporting the allegation of failure to meet professional standards or misconduct.

(2) An appropriate health care accreditation organization.

(3) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate.

**9.10(28) Secondary to a use or disclosure of protected health information.** The department may use or disclose protected health information that is secondary to a use or disclosure otherwise permitted or required by these rules, such as when a visitor in a facility overhears a doctor speaking to a subject about the subject's health.

**9.10(29) De-identified data or a limited data set.**

*a. De-identified information.* The department may use or disclose protected health information to create information that is de-identified under the conditions specified in 45 CFR 164.514, paragraphs "a" through "c," as amended to August 14, 2002.

*b. Limited data set.* The department may use or disclose a limited data set under the conditions specified at 45 CFR 164.514, paragraph "e," as amended to August 14, 2002, when the department enters into a data use agreement for research, public health, or health care operations.

**441—9.11(22) Availability of records.** This rule lists the department records which are open to the public, those which are confidential, and those which are partially open and partially confidential.

Department records are listed by category according to the legal basis for confidential treatment (if any). A single record may contain information from several categories.

The department administers several federally funded programs and is authorized by Iowa Code section 22.9 to enforce confidentiality standards from federal law and regulation as required for receipt of the funds. Where federal authority is cited in this rule, the department has determined that the right to examine and copy public records under Iowa Code section 22.2 would cause the denial of funds, services, or essential information from the United States government that would otherwise be available to the department.

The chart indicates whether the records in this category contain personally identifiable information and indicates the legal authority for confidentiality and for the collection of personally identifiable information.

Abbreviations are used in the chart as follows:

<u>Code</u>	<u>Meaning</u>
O	The records are open for public inspection.
C	The records are confidential and are not open to public inspection.
O/C	The record is partly open and partly confidential.
PI	Personally identifiable information
NA	Not applicable

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
Records of council, commission and statutory committees	O/C	Iowa Code 21.5(4)	No	NA
Pharmaceutical and therapeutics committee records (including information related to the prices manufacturers or wholesalers charge for pharmaceuticals)	O/C	42 U.S.C. §1396r(8)(b)(3)(D) and Iowa Code 550	No	NA
Rule making	O	NA	No	NA
Declaratory order records	O/C	Iowa Code 217.30	No	NA
Rules and policy manuals	O	NA	No	NA
State plans	O	NA	No	NA
Publications	O	NA	No	NA
Statistical reports	O	NA	No	NA
Financial and administrative records	O	NA	No	NA
Personnel records	O/C	Iowa Code 22.7(11)	Yes	Iowa Code 217.1
Contracts and interagency agreements	O	NA	No	NA
Grant records				
• Child abuse prevention	O	NA	No	NA
• Mental health/mental retardation general allocation	O	NA	No	NA
• Mental health/mental retardation special allocation	O	NA	No	NA
• Developmental disabilities basic	O	NA	No	NA
• Alcohol/drug abuse/mental health block	O	NA	No	
• National Institute of Mental Health	O	NA	No	
• Pregnancy prevention	O	NA	No	NA
• Juvenile community-based services	O	NA	No	NA
• Runaway prevention	O	NA	No	NA
Collection service center payment records	C	Iowa Code 252B.9(2); 42 U.S.C. §654a(d); 45 CFR §307.13	Yes	Iowa Code 252B.9, 252B.13A, 252B.16
Licensing, registration and approval				
• Juvenile detention and shelter care facilities	O/C	Iowa Code 217.30	No	NA
• Adoption investigators	O	NA	Yes	Iowa Code 600.2
• Supervised apartment living arrangement	O	NA	No	NA
• Mental health providers	O	NA	No	NA
• Family-life homes	O/C	Iowa Code 217.30	Yes	Iowa Code 234.6
• Foster care facilities	O/C	Iowa Code 237.9	Yes	Iowa Code 237
• Child care facilities	O/C	Iowa Code 237A.7	Yes	Iowa Code 237A
• Child-placing agencies	O/C	Iowa Code 238.24	No	NA
• Health care facilities	O/C	Iowa Code 135C.19	No	NA
Appeal records	O/C	Iowa Code 217.30	Yes	Iowa Code 217.1
Litigation files	O/C	Iowa Code 217.30, 22.7(4), 622.10	Yes	Iowa Code 217.1
Service provider records				
• Purchase of service providers	O/C	Iowa Code 217.30	Yes	Iowa Code 234.6
• Medicaid providers	O/C	Iowa Code 217.30, 42 U.S.C. §1396a(7), 42 CFR 431.300 to 307 as amended to November 13, 1996	Yes	Iowa Code 249A.4
• Residential care facilities	O/C	Iowa Code 217.30	No	NA
All service or assistance client records	C	Iowa Code 217.30	Yes	Iowa Code 217.1

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
• Family investment program	C	Iowa Code 217.30; 42 U.S.C. §602(a)(1) and §1306a	Yes	Iowa Code 239B
• Child care assistance	C	Iowa Code 237A.13	Yes	Iowa Code 237A
• State Supplementary Assistance	C	Iowa Code 217.30	Yes	Iowa Code 249
• Medicaid	C	Iowa Code 217.30; 42 U.S.C. §1396a(7); 42 CFR 431.300 to 307 as amended to November 13, 1996	Yes	Iowa Code 249A.4
• HAWK-I	C	Iowa Code 514I; 42 CFR 457.1110 as amended to January 11, 2001	Yes	Iowa Code 514I.4
• Food assistance	C	Iowa Code 217.30; 7 U.S.C. §2020(e)8 and 7 CFR 272.1 (c) and (d) as amended to January 1, 1987	Yes	Iowa Code 234.6
• Foster care	C	Iowa Code 237.9	Yes	Iowa Code 237.3 to 237.5
• Title IV-E foster care and adoption assistance	C	Iowa Code 217.30; 42 U.S.C. §671(a)(8); 45 CFR 1355.30(1) as amended to November 23, 2001	Yes	Iowa Code 217.1, Iowa Code 600.17 to 600.22
• Refugee resettlement	C	Iowa Code 217.30; 45 CFR 400.27 as amended to March 22, 2000	Yes	Iowa Code 217.1
• Substance abuse	C	Iowa Code 125.37 and 125.93; 42 U.S.C. §29 dd. 3 and ee. 3; 42 CFR Part 2 as amended to October 1, 2002; 38 U.S.C. §4132	Yes	Iowa Code 125, 218, 219 and 234.6 and 249A.4
• State institution resident records	C	Iowa Code 218.22, 229.24 and 229.25	Yes	Iowa Code 218.1
Program records				
• Child support recovery	C	Iowa Code 252B.9 and 252G.5; 42 U.S.C. §654(26), 42 U.S.C. §654a(d); 45 CFR §303.21 and 307.13	Yes	Iowa Code 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, 252K, and 144.13, 144.26, 232.147, 234.39, 595.4, 598.22B, and 600.16A
• Child abuse	C	Iowa Code 235A.13, 235A.15, 235A.16, and 235A.17	Yes	Iowa Code 235A.14
• Dependent adult abuse	C	Iowa Code 235B.1, par 4(a)	Yes	Iowa Code 235B.1
• Adoption	C	Iowa Code 600.16 and 600.24	Yes	Iowa Code 600.8 and 600.16
Client records may contain information from restricted sources:				
• Federal tax returns	C	Iowa Code 422.20(2); 26 U.S.C. §6103	Yes	Iowa Code 217.1, 234.6(7), 239B, 249A, 252B
• Department of revenue	C	Iowa Code 421.17, 422.20(1)	Yes	Iowa Code 252B.5 and 252B.9
• Department of workforce development	C	Iowa Code 217.30; 42 U.S.C. §503(d) and (e)	Yes	Iowa Code 217.1, 234.6(7), 239B, 249A, 249C, 252B.9
• Income and eligibility verification system	C	Iowa Code 217.30; 42 U.S.C. §1230b-7	Yes	Iowa Code 217.1, 234.6(7), 239B, 249A

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
• Department of public safety	C	Iowa Code 692.2, 692.3, 692.8 and 692.18	Yes	Iowa Code 237.8, 237A.5, 252B.9
• United States Department of Health and Human Services	C	Iowa Code 217.30; 42 CFR Part 401.134(c) as amended to October 1, 2002	Yes	Iowa Code 217.1, 234.6(7), 239B, 249, 249A, 252B
• Peer review organization	C	Iowa Code 217.30; 42 U.S.C. §1320c-9	Yes	Iowa Code 249A.4
• Juvenile court	C	Iowa Code 232.48, 232.97 and 232.147 to 232.151	Yes	Iowa Code 232 and 234.6
Other information				
• Mental health information	C	Iowa Code 228.2(1)	Yes	Iowa Code 217, 219, 222, 229
• Information received by a licensed social worker	C	Iowa Code 154C.5	Yes	Iowa Code 217.1
• Debtors to the department	C	Iowa Code 537.7103(3)	Yes	Iowa Code 217.1
• Health care facility complaint and citation records	C	Iowa Code 135C.19	No	Iowa Code 249A.4, 135C.19
• Hospital records, medical records, and professional counselor records	C	Iowa Code 22.7(2)	Yes	Iowa Code 218, 219, 222, 229
• Privileged communication and work products of attorneys representing the department	C	Iowa Code 22.7(4), Iowa Code of Professional Responsibility for Lawyers, Canon 4	No	NA
• Identity of volunteer informant who does not consent to release	C	Iowa Code 22.7(18)	No	Iowa Code 217.1
• School records	C	Iowa Code 22.7(1)	Yes	Iowa Code 218.1 and 234.6
• Library circulation records	C	Iowa Code 22.7(13) and (14)	No	Iowa Code 217.1
• Sealed bids prior to public opening	C	Iowa Code 72.3	No	NA
• Protected health information	C	HIPAA	Yes	Iowa Code 218.1, 249A.4, 514I.4

[ARC 1262C, IAB 1/8/14, effective 3/1/14]

**441—9.12(22,252G) Personally identifiable information.** The confidentiality provisions affecting records described in this rule are addressed in rule 441—9.11(22).

**9.12(1) Nature and extent.** The personally identifiable information collected by the department varies by the type of record. The nature and extent of personally identifiable information is described below:

*a. Recipients of assistance.* Several different types of department records contain personally identifiable information about recipients of assistance programs such as food assistance, Medicaid, the family investment program, child care assistance, state supplementary assistance, refugee cash and medical assistance, and commodity supplemental foods.

(1) Client case file. Local office case files contain identifying information, demographic information, household composition, and income and resource information about applicants for and recipients of assistance, as well as any other persons whose circumstances must be considered in determining eligibility. Records may contain information about employment, disability, or social circumstances. Records identify the kind and amount of benefits received and what proof was obtained to verify the recipient's eligibility. Case files contain correspondence, appeal requests and decisions, and documentation of department actions.

(2) Local office administrative records. Client names and program data are kept in card files, appointment logs, worker case lists, and issuance records.

(3) Data processing systems. Client identifying information, eligibility data, and payment data are kept in the following systems. Some of these records are also kept on microfiche.

<u>System</u>	<u>Function</u>
Automated Benefit Calculation System	Determines eligibility for FIP, food assistance, Medicaid
Automated Child Abuse and Neglect System	Inactive child abuse/neglect system
Appeals Logging and Tracking System	Tracks client appeals
BCCT Program	Establishes Medicaid eligibility for breast and cervical cancer clients
Change Reporting System	Tracks client-reported changes and produces forms needed for client-reported changes
Diversion System	Tracks clients using diversion benefits
Electronic Payment Processing and Inventory Control System	Electronically issues food assistance
Eligibility Tracking System	Tracks clients' FIP eligibility and hardship status
Family and Children's Services System	Tracks foster care, adoption, family-centered and family preservation services
Food Stamps Case Reading Application	Food assistance accuracy tool used to record case reading information
Health Insurance Premium Payment System	Health insurance premium payment
Iowa Collection and Reporting System	Tracks child support recovery processes
Iowa Central Employee Registry	Child support new hire reporting system
Iowa Eligibility Verification System	Federal social security number verification and benefits
Iowa Plan Program	Assigns group codes for Iowa Plan clients
Individualized Services Information System	Used to establish facility eligibility, process data to and from ABC and Medicaid fiscal agent, establish waiver services, providers, and eligibility
Issuance History	Displays benefit issuances for FIP and food assistance
KACT System	Authorizes foster care service units
MEPD Premium Payment Program	Accounting system for billing and payment for Medicaid for employed people with disabilities program
Managed Health Care Program	Assigns managed health care providers to clients
Medicaid Management Information Systems	Process clients' Medicaid claims and assign Medicaid coverage to clients
Overpayment Recoupment System	Used to recover money from FIP, Food Assistance, Medicaid, Child Care Assistance, PROMISE JOBS, and HAWK-I clients
Public Information Exchange	Data exchange between states
PJCASE	Iowa Workforce Development interface with PROMISE JOBS
Purchase of Social Services System	Purchased services (mostly child care and in-home health clients)
Presumptive Eligibility Program	Establishes Medicaid eligibility for presumptive eligibility clients

<u>System</u>	<u>Function</u>
Quality Control System	Selects sample for quality control review of eligibility determination
RTS Claims Processing System	Processes rehabilitative treatment claims for federal match
State Data Exchange Display	State data exchange information for supplemental security income recipients
Social Security Buy-In System	Medicare premium buy-in
Social Services Reporting System	Services reporting system for direct and purchased services
Statewide Tracking of Assessment Reports	Tracks child abuse reports

(4) Quality control records. Files are developed containing data required to verify the correctness of department eligibility and benefit decisions for selected clients.

(5) Appeals. Records containing client eligibility and payment information are created by the department of inspections and appeals when a client (or, for Medicaid, a provider) requests a hearing on a department action.

(6) Fraud. When a client is suspected of fraud, the department of inspections and appeals generates an investigative record containing information pertinent to the circumstances of the case.

(7) Recoupment. When benefits have been overpaid, a record is established by the department of inspections and appeals concerning the circumstances of the overpayment and the client's repayment.

*b. Recipients of social services.* Several kinds of department records contain personally identifiable information about applicants for and recipients of direct or purchased social services.

(1) Client case records. Local offices create client case files containing identifying information and demographic information; income data; information substantiating the need for services, which may include medical, psychological or psychiatric reports; social history; the department evaluation of the client's situation; documentation of department actions; and provider reports. Records may contain court orders and reports.

(2) Local office administrative records. Client names and services data appear in records such as card files, case lists, and appointment logs.

(3) Data processing systems. Client identifying information, demographic data, and services eligibility data are stored in the service reporting system. The purchase of services system contains invoice and service payment data. The child and adult protection system contains information from abuse reports and investigations. Some of these records are also kept on microfiche.

(4) Appeals. Records containing client identifying information and eligibility information are created by the department of inspections and appeals when a client requests a hearing on a department action.

(5) Adoption records. The department keeps a master card file on all adoptions in Iowa as required in Iowa Code section 235.3, subsection 7. This record is also kept on microfilm.

The Iowa Adoption Exchange contains records on special needs children available for adoption and on families that have indicated an interest in adopting special needs children.

The department also keeps records on adoptions in which it has provided services. These files include the home study, information about the child, and legal documents. These records are also kept on microfiche.

(6) Abuse registry. Child and dependent adult abuse records contain names and information of the alleged victim and the victim's family, data on the reported abuse, details of injury, investigative data, name of alleged perpetrator, names of reporters, collateral contacts and findings.

(7) Interstate compact records. The department maintains records on placement of children across state lines. These records contain identifying information about the children and the conditions of their placement, as well as progress reports. Some of the records are kept on microfiche.

(8) Guardianship records. The department maintains records on all children under its guardianship. The records concern the children's characteristics and placements. Some of these records are kept on microfiche.

*c. Institutions.* Institution resident records may contain identifying and demographic information, medical and social histories, treatment records, treatment plans, educational information, admission procedures, financial accounts, county billings, residential unit notes, vocational information, economic data and information about personal effects. Some of this information is kept on microfiche.

Automated data processing systems associated with institutional client records include admission and discharge systems for the juvenile institutions and for the mental health and mental retardation institutions, institutional billing systems, client banking systems, and client data systems.

*d. Child support recovery unit (CSRU) records.* These records contain information such as client identifiers, demographic information, divorce decrees, child support orders, absent parent identifiers, employment history and physical characteristics of absent parents, payment history records, and termination of parental rights.

*e. Collection services center.* The collection services center maintains records of support orders issued or filed in Iowa that have been converted to the collection services center system. These records identify the person paying and the person receiving support, specify the support obligations, and contain a record of payments made. Most records are on an automated data processing system. Paper records may also be kept, including conversion documents, orders, and correspondence.

*f. Contractor records for individual providers.* Records of individual purchase of service and Medicaid providers contain information such as names of owners and employees, names of clients served, eligibility data, amounts of payment for clients, and kinds of services received by clients.

*g. Regulatory files on individual providers.* Files on persons who apply to be licensed, certified, registered, or approved by the department contain identifying information, a description of the person's operation or premises, and a department evaluation of the information collected. Files may contain data on criminal records and abuse registry records on the person and any employees. Files may contain information naming clients served (for example, in complaints or incident reports). Some of these records are also kept on microfilm.

*h. Personnel files.* The department maintains files containing information about employees, families and dependents, and applicants for paid or volunteer positions within the department. The files contain payroll records, biographical information, medical information pertaining to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding and information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship.

**9.12(2) Data processing matching.**

*a. Internal.* All data processing systems operated by the department which have comparable personally identifiable data elements permit the matching of personally identifiable information. (See subrule 9.12(1) for a description of these systems.) Matches which are routinely done include the following:

(1) Data from the service reporting system is matched with data from the purchase of service payment system for service eligibility and with the activity reporting system for cost allocation. Matches are also done with the state identification portion of the automated benefit calculation system.

(2) The automated benefit calculation system matches with the Medicaid eligibility system, the facility payment system, the child support collections system, the employment and training systems, the electronic payment processing and inventory control system, the eligibility tracking system, the Medicare buy-in system, the individualized services information system-waiver payment system, and the income eligibility and verification system.

(3) The Medicaid eligibility system matches information with the Medicaid management information system and the collection and recovery system.

*b. External.*

(1) The state data exchange matches information on department clients with records on recipients of supplemental security income.

(2) The Medicare buy-in system matches information with the Social Security Administration.

(3) The income and eligibility verification system matches information on department clients with income records from department of workforce development records on unemployment compensation and wages, tax records from the Internal Revenue Service, wage records and social security benefit records from the Social Security Administration, and public assistance records from other states.

(4) Data from the collections and reporting system is matched with state and federal tax records, and with client records on the automated benefit calculation system.

(5) Data on department clients is matched with the administering agency for the Workforce Investment Act and with private agencies working to help employers collect benefits under the work opportunity tax credit program.

(6) Reports on disqualified food stamp recipients from other states are received from the United States Department of Agriculture to ensure that recipients are not evading penalties by reapplying in Iowa.

(7) A list of recipients of benefits under the family investment program is released annually to the Internal Revenue Service for matching with records of dependents claimed.

(8) A list of applicants for and recipients of the family investment program (FIP), the Medicaid program, and the food assistance program is matched with records on Iowa motor vehicle registration files to assist in the identification of countable resources.

(9) The Medicaid management information system matches data on medical assistance recipients against data on insureds that is submitted by insurance carriers under rule 441—76.13(249A) in order to identify third-party payers for medical assistance recipients.

*c. Centralized employee registry (CER) database.* The CER receives data concerning employees and contractors who perform labor in Iowa. Information reported by Iowa employers about employees includes the employee's name, address, social security number, date of birth, beginning date of employment, whether health insurance is available, and when it may be available. Information reported by Iowa income payers about contractors is limited to the contractor's name, address, social security number, and date of birth, if known.

State agencies accessing the CER shall participate in proportionate cost sharing for accessing and obtaining information from the registry. Cost sharing shall include all costs of performing the match including costs for preparing the tapes and central processing unit time. Costs shall be specified in a 28E agreement with each agency. CER matches include the following data matches with:

(1) The child support collections and reporting system for the establishment and enforcement of child and medical support obligations.

(2) Other department of human services systems for the purpose of gathering additional information and verification for use in the determination of eligibility or calculation of benefits.

(3) The department of employment services for the determination of eligibility or calculation of unemployment benefits, and to monitor employer compliance with job insurance tax liability requirements.

(4) The department of workforce development to verify employment of participants in the PROMISE JOBS program.

(5) The department of revenue for the recoupment of debts to the state.

(6) The department of inspections and appeals for the recoupment of debts owed to the department of human services.

#### **441—9.13(217) Distribution of informational materials.**

**9.13(1) Requirements for distribution.** All material sent or distributed to clients, vendors, or medical providers shall:

*a.* Directly relate to the administration of the program.

*b.* Have no political implications.

*c.* Contain the names only of persons directly connected with the administration of the program.

*d.* Identify them only in their official capacity with the agency.

**9.13(2) *Distribution prohibited.*** The department shall not distribute materials such as holiday greetings, general public announcements, voting information, and alien registration notices.

**9.13(3) *Distribution permitted.*** The department may distribute materials directly related to the health and welfare of clients, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

**441—9.14(17A,22) Special policies and procedures for protected health information.**

**9.14(1) *Minimum necessary.*** When using or disclosing protected health information or when requesting protected health information from another covered entity, the department shall make reasonable efforts, as described in paragraphs 9.14(1)“a” through “e,” to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

*a.* This requirement does not apply in the following circumstances:

- (1) Disclosures to or requests by a health care provider for treatment.
- (2) Uses or disclosures made to the subject.
- (3) Uses or disclosures made pursuant to an authorization.
- (4) Disclosures made to the Secretary of Health and Human Services.
- (5) Uses or disclosures that are required by law.
- (6) Uses or disclosures that are required for compliance with this chapter.

*b.* The department shall take the following actions:

(1) Identify those persons or classes of persons, as appropriate, in its workforce who need access to protected health information to carry out their duties.

(2) For each person or class of persons, identify the category or categories of protected health information to which access is needed and any conditions appropriate to the access.

(3) Make reasonable efforts to limit the access of these persons or classes.

*c.* For any type of disclosure that it makes on a routine and recurring basis, the department shall implement policies and procedures (which may be standard protocols) that limit the amount of the protected health information disclosed to that reasonably necessary to achieve the purpose of the disclosure.

For all other disclosures, the department shall develop criteria designed to limit the protected health information disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought. The department shall review requests for disclosure on an individual basis in accordance with the criteria.

The department may rely, if reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:

(1) Making permitted disclosures to a public official, provided the public official indicates that the information requested is the minimum necessary for the stated purposes;

(2) The information is requested by another covered entity; or

(3) The information is requested for the purpose of providing professional services to the department by a professional who is a workforce member or business associate of the department if the professional indicates that the information requested is the minimum necessary for the stated purpose.

*d.* Minimum necessary requests.

(1) When requesting information from other covered entities, the department shall limit any request for protected health information to that which is reasonably necessary to accomplish the purpose for which the request is made.

(2) For a request that is made on a routine and recurring basis, the department shall implement policies and procedures (which may be standard protocols) that limit the protected health information requested to the amount reasonably necessary to accomplish the purpose for which the request is made.

(3) For all other requests, the department shall develop criteria designed to limit the request for protected health information to the information reasonably necessary to accomplish the purpose for which the request is made and to review requests for disclosure on an individual basis in accordance with the criteria.

*e.* For all uses, disclosures, or requests to which the minimum necessary requirements apply, the department shall not use, disclose or request an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request.

**9.14(2)** *Uses and disclosures for premium rating and related purposes.* If a health plan receives protected health information for the purpose of premium rating or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and if the health insurance or health benefits are not placed with the health plan, the health plan shall not use or disclose the protected health information for any other purpose, except as may be required by law.

**9.14(3)** *Verification and documentation.*

*a.* Before any disclosure of protected health information, the department shall obtain verification or documentation as follows:

(1) Verify the identity of a person requesting protected health information and the person's authority to access protected health information, if the department does not know the identity or authority of the person. This requirement is waived for disclosures to persons involved in the subject's care or for notification purposes, as described at subrule 9.7(3).

(2) Obtain any oral or written documentation, including statements and representations, from the person requesting the protected health information when this is a condition of the disclosure under this chapter.

*b.* The following constitute appropriate verification or documentation, if reasonable under the circumstances:

(1) Documentation, statements, or representations. The department may rely on documentation, statements, or representations that, on their face, meet the applicable requirements.

(2) Identity of public officials. When disclosure of protected health information is requested by a public official or a person acting on behalf of the public official, the department may rely on any of the following to verify identity:

1. In-person presentation of an agency identification badge, other official credentials, or other proof of government status.

2. A written request on the appropriate government letterhead.

3. A written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency, such as a contract for services, memorandum of understanding, or purchase order, that establishes the person is acting on behalf of the public official.

(3) Authority of public officials. When the disclosure of protected health information is requested by a public official or a person acting on behalf of the public official, the department may rely on any of the following to verify authority:

1. A written statement of the legal authority under which the information is requested.

2. If a written statement would be impracticable, an oral statement of the legal authority.

3. An order issued by a judicial or administrative tribunal.

(4) Exercise of professional judgment. The requirements of this subrule are met if the department relies on the exercise of professional judgment in use or disclosure to persons involved in the subject's care or for notification purposes, in accordance with subrule 9.7(3), or acts on a good-faith belief in making a disclosure to avert a serious threat to health or safety, in accordance with subrule 9.10(18).

**9.14(4)** *Notice of privacy practices for protected health information.* A subject has a right to adequate notice of the uses and disclosures of protected health information that may be made by the department, and of the subject's rights and the department's legal duties with respect to protected health information.

**9.14(5)** *Right to receive an accounting of disclosures.* Within the limits described in this subrule, a subject has a right to receive an accounting of the disclosures of protected health information listed in paragraph 9.14(5) "a," including disclosures to or by business associates of the department. A subject shall request an accounting using Form 470-3985, Request for a List of Disclosures.

*a. Disclosures that may be included in an accounting.* A subject's right to receive an accounting of disclosures made by the department, or to or by business associates of the department, is limited to the following disclosures that do not require an authorization or an opportunity for the subject to agree or object:

- (1) For health oversight activities described at subrule 9.10(2).
- (2) For judicial and administrative proceedings described at subrule 9.10(5).
- (3) For law enforcement purposes described at subrule 9.10(15).
- (4) For averting a threat to health or safety described at subrule 9.10(18).
- (5) To meet requirements of law described at subrule 9.10(19).
- (6) For public health activities described at subrule 9.10(22).
- (7) For disclosures about suspected victims of domestic violence described at subrule 9.10(23).
- (8) For disclosures about suspected victims of abuse or neglect described in 441—Chapter 9.
- (9) To coroners, medical examiners, and funeral directors described at subrule 9.10(24).
- (10) For cadaveric organ, eye, or tissue donation described at subrule 9.10(25).
- (11) For specialized government functions described at subrule 9.10(26), except those made for national security or intelligence purposes.
- (12) By whistle blowers as described at subrule 9.10(27).

*b. Content of the accounting.* The department shall provide the subject who submits Form 470-3985, Request for a List of Disclosures, with a written accounting of disclosures that meets the following requirements.

(1) The accounting shall include disclosures of protected health information that occurred during the six years (or the shorter time requested by the subject) before the date of the request. However, disclosures that occurred before April 14, 2003, are not included in an accounting.

(2) Except for limitations regarding multiple disclosures to the same person or organization, the accounting shall include for each disclosure:

1. The date of the disclosure.
2. The name of the organization or person who received the protected health information and, if known, the address of the organization or person.
3. A brief description of the protected health information disclosed.
4. A brief statement of the purpose of the disclosure that reasonably informs the subject of the basis for the disclosure or, instead of the statement, a copy of a written request for a disclosure.

(3) If, during the period covered by the accounting, the department has made multiple disclosures of protected health information to a person or organization requesting a disclosure, the accounting may, with respect to the multiple disclosures, provide:

1. The information required by subparagraph 9.14(5) "b"(2), for the first disclosure during the accounting period;
2. The frequency, periodicity, or number of the disclosures made during the accounting period; and
3. The date of the last disclosure during the accounting period.

*c. Time limits for providing the accounting.* The department shall act on the subject's request for an accounting no later than 60 days after receipt of a request, as follows:

- (1) The department shall provide the subject with the accounting requested; or
- (2) If the department is unable to provide the accounting within these 60 days, the department may extend the due date one time, for a period not to exceed 30 days. In order to extend the due date, the department shall provide the subject with a written statement of the reasons for the delay and the date by which the department shall provide the accounting. The department shall provide this written statement within the 60-day period after receipt of the request for an accounting.

*d. Fee for accounting.* The department shall provide to a subject one accounting without charge in any 12-month period. The department may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same subject within the 12-month period, as set forth in subrule 9.3(7), provided that the department:

- (1) Informs the subject in advance of the fee; and

(2) Provides the subject with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

*e. Suspension of right.* The department shall temporarily suspend a subject's right to receive an accounting of disclosures made to a health oversight agency or law enforcement official, as permitted in this chapter, if the agency or official provides the department with a statement that the accounting would likely impede the agency's activities and specifies the time for which a suspension is required.

(1) If the agency or official statement is submitted in writing, the department shall suspend the right to receive accounting for the time specified by the agency or official.

(2) If the agency or official statement is made orally, the department shall:

1. Document the statement, including the identity of the agency or official making the statement;
2. Temporarily suspend the subject's right to an accounting of disclosures subject to the statement;

and

3. Limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless the agency or official statement is submitted in writing during that time.

**9.14(6) Complaint procedure.** A person who believes the department is not complying with the rules on protected health information or with the applicable requirements of 45 CFR Part 160 as amended to August 14, 2002, or with the applicable standards, requirements, and implementation specifications of 45 CFR of Subpart E of Part 164 as amended to August 14, 2002, may file a complaint with the department's privacy office or with the Secretary of Health and Human Services.

*a.* Complaints to the department's privacy office shall be in writing and may be delivered personally or by mail to the DHS Privacy Office, 1305 E. Walnut Street, First Floor, Des Moines, Iowa 50319-0114. Complaints regarding facilities may be sent to the applicable facility.

*b.* Complaints to the Secretary of Health and Human Services shall be made using the procedures set forth in 45 CFR 160.306 as amended to August 14, 2002.

**9.14(7) Appeal rights.**

*a.* If the subject disputes a decision by the privacy officer, the department's designated licensed health care professional, or the facility administrator on any of the following requests, the subject may appeal the decision in accordance with 441—Chapter 7.

- (1) A request for restriction on use or disclosure of protected health information.
- (2) A request for confidential communication of protected health information.
- (3) A request for access to protected health information.
- (4) A request to amend protected health information.
- (5) A request for accounting of disclosures.

*b.* The privacy officer or facility shall assist the subject in making the appeal, if needed.

*c.* Appeals shall be:

(1) Mailed to the Appeals Section, Fifth Floor, Iowa Department of Human Services, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114; or

(2) Submitted electronically at [www.dhs.state.ia.us/appeals.asp](http://www.dhs.state.ia.us/appeals.asp).

**9.14(8) Record retention.** Notwithstanding any other department rule to the contrary, protected health information shall be retained for at least six years from the date of creation or the date when the information last was in effect, when required by 45 CFR 164.530, paragraph "j," as amended to August 14, 2002.

#### **441—9.15(17A,22) Person who may exercise rights of the subject.**

**9.15(1) Adults.** When the subject is an adult, including an emancipated minor, the subject's rights under this rule may also be exercised by the subject's legal or personal representative, except as provided in subrule 9.15(3).

**9.15(2) Minors.** Within the limits of subrule 9.15(3), when the subject is an unemancipated minor, the subject's rights under this rule shall be exercised only by the subject's legal representative, except as follows:

*a.* When the department otherwise deals with the minor as an adult, as in the case of minor parents under the family investment program.

b. When otherwise specifically provided by law. However, minor subjects shall be granted access to their own records upon request, subject to the limits in rule 441—9.9(17A,22).

**9.15(3) Exceptions.**

a. *Scope of authority.* Legal and personal representatives may act only within the scope of their authority. For protected health information, the designation must reflect the subject's ability to make health care decisions and receive protected health information. For example, court-appointed conservators shall have access to and authority to release only the following information:

- (1) Name and address of subject.
- (2) Amounts of assistance or type of services received.
- (3) Information about the economic circumstances of the subject.

b. *Mental health information.* Only an adult subject or a subject's legal representative may consent to the disclosure of mental health information. Records of involuntary hospitalization shall be released only as provided in Iowa Code section 229.24. Medical records of persons hospitalized under Iowa Code chapter 229 shall be released only as provided in Iowa Code section 229.25.

c. *Substance abuse information.* Only the subject may consent to the disclosure of substance abuse information, regardless of the subject's age or condition.

d. *Failure to act in good faith.* If the department has reason to believe that the legal or personal representative is not acting in good faith in the best interests of the subject, the department may refuse to release information on the authorization of the legal or personal representative.

e. *Abuse, neglect, and endangerment situations.* Notwithstanding a state law or any other requirement of this chapter, the department, in the exercise of professional judgment, may elect not to treat a person as a subject's personal representative if:

- (1) The department has reason to believe that the subject has been or may be subjected to domestic violence, abuse, or neglect by the person; or
- (2) The department has reason to believe that treating the person as a personal representative could endanger the subject.

f. *Protected health information.* A parent, guardian, or other person acting in place of a parent who does not represent the minor for protected health information may still access protected health information about the minor if required by law.

g. *Deceased subjects.* If, under applicable law, an executor, administrator, or other person has authority to act on behalf of a deceased subject or of the subject's estate, the department shall treat that person as a personal representative.

h. *Other.* If, under applicable law, the subject of a confidential record is precluded from having a copy of a record concerning the subject disclosed to a third party, the department shall not treat the third party as a personal representative.

These rules are intended to implement Iowa Code sections 17A.3, 22.11, 217.6 and 217.30, Iowa Code chapters 228 and 252G, and the Health Insurance Portability and Accountability Act of 1996.

[Filed emergency 11/25/75—published 12/15/75, effective 11/25/75]

[Filed 12/17/76, Notice 11/3/76—published 1/12/77, effective 2/16/77]

[Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 11/7/79]

[Filed 4/23/81, Notice 3/4/81—published 5/13/81, effective 6/17/81]

[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]

[Filed 3/4/85, Notice 12/19/84—published 3/27/85, effective 5/1/85]

[Filed 7/25/86, Notice 5/21/86—published 8/13/86, effective 10/1/86]

[Filed 11/14/86, Notice 10/8/86—published 12/3/86, effective 2/1/87]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[Filed 4/22/88, Notice 2/10/88—published 5/18/88, effective 7/1/88]

[Filed without Notice 12/8/88—published 12/28/88, effective 2/1/89]

[Filed emergency 6/29/89 after Notice 5/3/89—published 7/26/89, effective 7/1/89]

[Filed 10/10/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]

[Filed 12/15/89, Notice 7/26/89—published 1/10/90, effective 3/1/90]

[Filed emergency 10/12/90 after Notice 8/22/90—published 10/31/90, effective 11/1/90]

- [Filed 10/12/90, Notice 8/22/90—published 10/31/90, effective 1/1/91]
- [Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
- [Filed emergency 6/14/91 after Notice 5/1/91—published 7/10/91, effective 7/1/91]
- [Filed 8/12/93, Notice 6/23/93—published 9/1/93, effective 11/1/93]
- [Filed 1/11/95, Notice 11/23/94—published 2/1/95, effective 4/1/95]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 8/12/98, Notice 6/17/98—published 9/9/98, effective 11/1/98]
- [Filed 9/12/00, Notice 7/12/00—published 10/4/00, effective 12/1/00]
- [Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
- [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
- [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
- [Filed 9/23/04, Notice 8/4/04—published 10/13/04, effective 11/17/04]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed 8/12/05, Notice 6/8/05—published 8/31/05, effective 11/1/05]
- [Filed emergency 1/19/07—published 2/14/07, effective 1/20/07]
- [Filed ARC 0420C (Notice ARC 0255C, IAB 8/8/12), IAB 10/31/12, effective 1/1/13]
- [Filed ARC 1262C (Notice ARC 1045C, IAB 10/2/13), IAB 1/8/14, effective 3/1/14]



CHAPTER 51  
ELIGIBILITY

[Prior to 7/1/83, Social Services[770] Ch 51]

[Prior to 2/11/87, Human Services[498]]

**441—51.1(249) Application for other benefits.** An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

This rule is intended to implement Iowa Code section 249.3.

**441—51.2(249) Supplementation.** Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity shall be considered as income, and the payment shall be used to reduce the state supplementary assistance payment.

**441—51.3(249) Eligibility for residential care.**

**51.3(1) Licensed facility.** Payment for residential care shall be made only when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections and appeals pursuant to laws governing health care facilities.

**51.3(2) Physician's statement.** Payment for residential care shall be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification shall be updated whenever a change in the recipient's physical condition warrants reevaluation, but no less than every 12 months.

**51.3(3) Income eligibility.** The resident shall be income eligible when the income according to 441—paragraph 52.1(3) "a" is less than 31 times the per diem rate of the facility. Partners in a marriage who both enter the same room of the residential care facility in the same month shall be income eligible for the initial month when their combined income according to 441—paragraph 52.1(3) "a" is less than twice the amount of allowed income for one person (31 times the per diem rate of the facility).

**51.3(4) Diversion of income.** Rescinded IAB 5/1/91, effective 7/1/91.

**51.3(5) Resources.** Rescinded IAB 5/1/91, effective 7/1/91.

This rule is intended to implement Iowa Code section 249.3.

**441—51.4(249) Dependent relatives.**

**51.4(1) Income.** Income of a dependent relative shall be less than \$370. When the dependent's income is from earnings, an exemption of \$65 shall be allowed to cover work expense.

**51.4(2) Resources.** The resource limitation for a recipient and a dependent child or parent shall be \$2,000. The resource limitation for a recipient and a dependent spouse shall be \$3,000. The resource limitation for a recipient, spouse, and dependent child or parent shall be \$3,000.

**51.4(3) Living in the home.** A dependent relative shall be eligible until out of the recipient's home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

**51.4(4) Dependency.** A dependent relative may be the recipient's ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative shall not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

[ARC 7605B, IAB 3/11/09, effective 4/15/09; ARC 9965B, IAB 1/11/12, effective 1/1/12; ARC 0064C, IAB 4/4/12, effective 5/9/12; ARC 0489C, IAB 12/12/12, effective 1/1/13; ARC 0633C, IAB 3/6/13, effective 5/1/13; ARC 1268C, IAB 1/8/14, effective 1/1/14]

**441—51.5(249) Residence.** A recipient of state supplementary assistance shall be living in the state of Iowa.

This rule is intended to implement Iowa Code section 249.3.

**441—51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles.** The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibles:

**51.6(1) Medicaid eligibility.** The recipient must be eligible for and receiving full medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spenddown or pay a premium to be eligible for medical assistance benefits.

**51.6(2) SSI eligibility.** The recipient shall meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

**51.6(3) Not otherwise eligible.** The recipient must not be eligible for benefits under another state supplementary assistance group.

**51.6(4) Medicare eligibility.** The recipient must be currently eligible for Medicare Part B.

**51.6(5) Living arrangement.** A recipient may live in one of the following:

- a. The person's own home.
- b. The home of another person.
- c. A group living arrangement.
- d. A medical facility.

**51.6(6) Income.** Income of a recipient shall be within the income limit for the person's Medicaid eligibility group, but must exceed 120 percent of the federal poverty level.

This rule is intended to implement Iowa Code section 249.3 as amended by 2005 Iowa Acts, House File 825, section 108.

**441—51.7(249) Income from providing room and board.** In determining profit from furnishing room and board or providing family life home care, \$370 per month shall be deducted to cover the cost, and the remaining amount treated as earned income.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

[ARC 7605B, IAB 3/11/09, effective 4/15/09; ARC 9965B, IAB 1/11/12, effective 1/1/12; ARC 0064C, IAB 4/4/12, effective 5/9/12; ARC 0489C, IAB 12/12/12, effective 1/1/13; ARC 0633C, IAB 3/6/13, effective 5/1/13; ARC 1268C, IAB 1/8/14, effective 1/1/14]

**441—51.8(249) Furnishing of social security number.** As a condition of eligibility applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

**441—51.9(249) Recovery.**

**51.9(1) Definitions.**

*“Administrative overpayment”* means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

*“Agency error”* means 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 local office.
6. Failure to make prompt revisions in payment following changes in policies requiring the changes as of a specific date.

*“Client”* means a current or former applicant or recipient of state supplementary assistance.

“*Client error*” means 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. It 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—76.10(249A).

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

**51.9(2)** *Amount subject to recovery.* The department shall recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

*a.* The department also shall seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

*b.* The incorrect expenditures may result from client or agency error, or administrative overpayment.

**51.9(3)** *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery, when known; and the reason for the incorrect expenditure.

**51.9(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 must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

**51.9(5)** *Repayment.* The repayment of incorrectly expended state supplementary assistance funds shall be made to the department.

**51.9(6)** *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

[Filed 2/19/76, Notice 1/12/76—published 3/8/76, effective 4/12/76]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed 12/17/76, Notice 11/3/76—published 1/12/77, effective 3/1/77]

[Filed emergency 5/24/77—published 6/15/77 effective 7/1/77]

[Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]

[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]

[Filed 7/17/78, Notice 5/31/78—published 8/9/78, effective 9/13/78]

[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]

[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]

[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]

[Filed 6/30/81, Notice 4/29/81—published 7/22/81, effective 9/1/81]

[Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]

[Filed 11/20/81, Notice 9/30/81—published 12/9/81, effective 2/1/82]

[Filed emergency 9/23/82—published 10/13/82, effective 9/23/82]

[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]

[Filed emergency 11/18/83, after Notice 10/12/83—published 12/7/83, effective 1/1/84]

[Filed emergency 12/11/84—published 1/2/85, effective 1/1/85]

[Filed without Notice 1/22/85—published 2/13/85, effective 4/1/85]

[Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]

[Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]

[Filed 4/29/86, Notice 3/12/86—published 5/21/86, effective 8/1/86]

[Filed emergency 12/22/86—published 1/14/87, effective 1/1/87]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[Filed emergency 12/10/87—published 12/30/87, effective 1/1/88]

[Filed emergency 12/8/88—published 12/28/88, effective 1/1/89]

- [Filed emergency 11/16/89—published 12/13/89, effective 1/1/90]
- [Filed 2/16/90, Notice 12/13/89—published 3/7/90, effective 5/1/90]
- [Filed emergency 12/13/90—published 1/9/91, effective 1/1/91]
- [Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
- [Filed 2/14/91, Notice 1/9/91—published 3/6/91, effective 5/1/91]
- [Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
- [Filed emergency 12/11/91—published 1/8/92, effective 1/1/92]
- [Filed 2/13/92, Notices 12/25/91, 1/8/92—published 3/4/92, effective 5/1/92]
- [Filed emergency 12/1/92—published 12/23/92, effective 1/1/93]
- [Filed 2/10/93, Notice 12/23/92—published 3/3/93, effective 5/1/93]
- [Filed emergency 12/16/93—published 1/5/94, effective 1/1/94]
- [Filed 12/16/93, Notice 10/27/93—published 1/5/94, effective 3/1/94]
- [Filed 2/10/94, Notice 1/5/94—published 3/2/94, effective 5/1/94]
- [Filed emergency 12/15/94—published 1/4/95, effective 1/1/95]
- [Filed 2/16/95, Notice 1/4/95—published 3/15/95, effective 5/1/95]
- [Filed emergency 12/12/95—published 1/3/96, effective 1/1/96]
- [Filed 2/14/96, Notice 1/3/96—published 3/13/96, effective 5/1/96]
- [Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]
- [Filed 2/12/97, Notice 1/1/97—published 3/12/97, effective 5/1/97]
- [Filed emergency 12/10/97—published 12/31/97, effective 1/1/98]
- [Filed 2/11/98, Notice 12/31/97—published 3/11/98, effective 5/1/98]
- [Filed emergency 12/9/98—published 12/30/98, effective 1/1/99]
- [Filed 2/10/99, Notice 12/30/98—published 3/10/99, effective 4/15/99]
- [Filed emergency 12/8/99—published 12/29/99, effective 1/1/00]
- [Filed 2/9/00, Notice 12/29/99—published 3/8/00, effective 5/1/00]
- [Filed emergency 12/14/00—published 1/10/01, effective 1/1/01]
- [Filed 2/14/01, Notice 1/10/01—published 3/7/01, effective 5/1/01]
- [Filed emergency 12/12/01—published 1/9/02, effective 1/1/02]
- [Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
- [Filed emergency 5/9/02—published 5/29/02, effective 6/1/02]
- [Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]
- [Filed emergency 12/12/02—published 1/8/03, effective 1/1/03]
- [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
- [Filed emergency 8/12/04 after Notice 6/23/04—published 9/1/04, effective 8/12/04]
- [Filed emergency 12/14/04—published 1/5/05, effective 1/1/05]
- [Filed 2/10/05, Notice 1/5/05—published 3/2/05, effective 4/6/05]
- [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
- [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
- [Filed emergency 12/14/05—published 1/4/06, effective 1/1/06]
- [Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
- [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed 3/14/07, Notice 1/3/07—published 4/11/07, effective 5/16/07]
- [Filed emergency 12/12/07—published 1/2/08, effective 1/1/08]
- [Filed 3/12/08, Notice 1/2/08—published 4/9/08, effective 5/14/08]
- [Filed emergency 12/10/08—published 12/31/08, effective 1/1/09]
- [Filed ARC 7605B (Notice ARC 7472B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]
- [Filed Emergency ARC 9965B, IAB 1/11/12, effective 1/1/12]
- [Filed ARC 0064C (Notice ARC 9964B, IAB 1/11/12), IAB 4/4/12, effective 5/9/12]
- [Filed Emergency ARC 0489C, IAB 12/12/12, effective 1/1/13]
- [Filed ARC 0633C (Notice ARC 0488C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
- [Filed Emergency ARC 1268C, IAB 1/8/14, effective 1/1/14]

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.

\$783	Care allowance
<u>\$100</u>	Personal allowance
\$883	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 . . . . . \$1,091
- b. Aged or disabled client, eligible spouse, and a dependent relative . . . . . \$1,452
- c. Blind client and a dependent relative . . . . . \$1,113
- d. Blind client, aged or disabled spouse, and a dependent relative . . . . . \$1,474
- e. Blind client, blind spouse, and a dependent relative . . . . . \$1,496

**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 \$29.66. 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 \$100 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.

[ARC 7605B, IAB 3/11/09, effective 4/15/09; ARC 8440B, IAB 1/13/10, effective 3/1/10; ARC 9965B, IAB 1/11/12, effective 1/1/12; ARC 0064C, IAB 4/4/12, effective 5/9/12; ARC 0489C, IAB 12/12/12, effective 1/1/13; ARC 0633C, IAB 3/6/13, effective 5/1/13; ARC 1268C, IAB 1/8/14, effective 1/1/14]

[Filed 2/19/76, Notice 1/12/76—published 3/8/76, effective 4/12/76]

[Filed emergency 6/9/76—published 6/28/76, effective 7/1/76]

[Filed emergency 7/29/76—published 8/23/76, effective 9/1/76]

[Filed 9/29/76, Notice 8/23/76—published 10/20/76, effective 11/24/76]

- [Filed 12/17/76, Notice 11/3/76—published 1/12/77, effective 3/1/77]
  - [Filed emergency 5/24/77—published 6/15/77, effective 7/1/77]
- [Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
  - [Filed emergency 5/8/78—published 5/31/78, effective 5/24/78]
  - [Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
- [Filed 7/17/78, Notice 5/31/78—published 8/9/78, effective 9/13/78]
- [Filed 11/7/78, Notice 4/19/78—published 11/29/78, effective 1/3/79]
  - [Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
  - [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
  - [Filed emergency 6/30/81 —published 7/22/81, effective 7/1/81]
- [Filed 2/26/82, Notice 10/28/81—published 3/17/82, effective 5/1/82]
  - [Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
  - [Filed emergency 7/1/82—published 7/21/82, effective 7/1/82]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
  - [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
  - [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed emergency 11/18/83, after Notice 10/12/83—published 12/7/83, effective 1/1/84]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
  - [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
  - [Filed emergency 12/11/84—published 1/2/85, effective 1/1/85]
  - [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
- [Filed emergency after Notice 6/14/85, Notice 5/8/85—published 7/3/85, effective 8/1/85]
  - [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
  - [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
  - [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
  - [Filed emergency 12/22/86—published 1/14/87, effective 1/1/87]
  - [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
  - [Filed emergency 12/10/87—published 12/30/87, effective 1/1/88]
  - [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
  - [Filed emergency 12/8/88—published 12/28/88, effective 1/1/89]
  - [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
  - [Filed emergency 11/16/89—published 12/13/89, effective 1/1/90]
- [Filed 2/16/90, Notice 12/13/89—published 3/7/90, effective 5/1/90]
  - [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
  - [Filed emergency 12/13/90—published 1/9/91, effective 1/1/91]
- [Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
  - [Filed 2/14/91, Notice 1/9/91—published 3/6/91, effective 5/1/91]
  - [Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
- [Filed 9/18/91, Notice 7/24/91—published 10/16/91, effective 12/1/91]
  - [Filed emergency 12/11/91—published 1/8/92, effective 1/1/92]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]<sup>1</sup>
  - [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
  - [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
  - [Filed 4/16/92, Notice 1/8/92—published 5/13/92, effective 7/1/92]
  - [Filed emergency 12/1/92—published 12/23/92, effective 1/1/93]
- [Filed 2/10/93, Notice 12/23/92—published 3/3/93, effective 5/1/93]
  - [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]

- [Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed emergency 12/16/93—published 1/5/94, effective 1/1/94]
- [Filed 12/16/93, Notice 10/27/93—published 1/5/94, effective 3/1/94]
- [Filed 2/10/94, Notice 1/5/94—published 3/2/94, effective 5/1/94]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
- [Filed emergency 10/12/94—published 11/9/94, effective 11/1/94]
- [Filed emergency 12/15/94—published 1/4/95, effective 1/1/95]
- [Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/1/95]
- [Filed 2/16/95, Notice 1/4/95—published 3/15/95, effective 5/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed emergency 10/31/95—published 11/22/95, effective 11/1/95]
- [Filed emergency 12/12/95—published 1/3/96, effective 1/1/96]
- [Filed 1/10/96, Notice 11/22/95—published 1/31/96, effective 4/1/96]
- [Filed 2/14/96, Notice 1/3/96—published 3/13/96, effective 5/1/96]
- [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]
- [Filed 2/12/97, Notice 1/1/97—published 3/12/97, effective 5/1/97]
- [Filed emergency 3/12/97—published 4/9/97, effective 4/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed 5/14/97, Notice 4/9/97—published 6/4/97, effective 8/1/97]
- [Filed emergency 12/10/97—published 12/31/97, effective 1/1/98]
- [Filed 2/11/98, Notice 12/31/97—published 3/11/98, effective 5/1/98]
- [Filed emergency 12/9/98—published 12/30/98, effective 1/1/99]
- [Filed 2/10/99, Notice 12/30/98—published 3/10/99, effective 4/15/99]
- [Filed emergency 12/8/99—published 12/29/99, effective 1/1/00]
- [Filed 2/9/00, Notice 12/29/99—published 3/8/00, effective 5/1/00]
- [Filed emergency 7/13/00—published 8/9/00, effective 8/1/00]
- [Filed emergency 10/11/00—published 11/1/00, effective 11/15/00]
- [Filed 11/8/00, Notice 8/9/00—published 11/29/00, effective 2/1/01]
- [Filed emergency 12/14/00—published 1/10/01, effective 1/1/01]
- [Filed 2/14/01, Notice 1/10/01—published 3/7/01, effective 5/1/01]
- [Filed emergency 4/11/01—published 5/2/01, effective 5/1/01]
- [Filed 6/13/01, Notice 5/2/01—published 7/11/01, effective 9/1/01]
- [Filed emergency 7/11/01—published 8/8/01, effective 8/1/01]
- [Filed 10/10/01, Notice 8/8/01—published 10/31/01, effective 1/1/02]
- [Filed emergency 12/12/01—published 1/9/02, effective 1/1/02]
- [Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
- [Filed emergency 5/9/02—published 5/29/02, effective 6/1/02]
- [Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]
- [Filed emergency 12/12/02—published 1/8/03, effective 1/1/03]
- [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
- [Filed 11/19/03, Notice 10/1/03—published 12/10/03, effective 2/1/04]
- [Filed emergency 8/12/04 after Notice 6/23/04—published 9/1/04, effective 8/12/04]
- [Filed emergency 12/14/04—published 1/5/05, effective 1/1/05]
- [Filed 2/10/05, Notice 1/5/05—published 3/2/05, effective 4/6/05]
- [Filed emergency 12/14/05—published 1/4/06, effective 1/1/06]
- [Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
- [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed 3/14/07, Notice 1/3/07—published 4/11/07, effective 5/16/07]

[Filed emergency 12/12/07—published 1/2/08, effective 1/1/08]  
[Filed 3/12/08, Notice 1/2/08—published 4/9/08, effective 5/14/08]  
[Filed emergency 12/10/08—published 12/31/08, effective 1/1/09]  
[Filed ARC 7605B (Notice ARC 7472B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]  
[Filed Without Notice ARC 8440B, IAB 1/13/10, effective 3/1/10]  
[Filed Emergency ARC 9965B, IAB 1/11/12, effective 1/1/12]  
[Filed ARC 0064C (Notice ARC 9964B, IAB 1/11/12), IAB 4/4/12, effective 5/9/12]  
[Filed Emergency ARC 0489C, IAB 12/12/12, effective 1/1/13]  
[Filed ARC 0633C (Notice ARC 0488C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]  
[Filed Emergency ARC 1268C, IAB 1/8/14, effective 1/1/14]

<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 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	\$29
165% of Federal Poverty Level	\$39
180% of Federal Poverty Level	\$44
200% of Federal Poverty Level	\$51
225% of Federal Poverty Level	\$56
250% of Federal Poverty Level	\$66
300% of Federal Poverty Level	\$86
350% of Federal Poverty Level	\$106
400% of Federal Poverty Level	\$124
450% of Federal Poverty Level	\$144
550% of Federal Poverty Level	\$182
650% of Federal Poverty Level	\$221
750% of Federal Poverty Level	\$262
850% of Federal Poverty Level	\$305
1000% of Federal Poverty Level	\$369
1150% of Federal Poverty Level	\$440
1300% of Federal Poverty Level	\$515
1480% of Federal Poverty Level	\$598

(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]

**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) Condition of eligibility for group plans.** The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

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

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of a spouse who cannot enroll in the plan independently of the other spouse shall not be terminated due to the other spouse's failure to cooperate.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

**75.21(2) 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(3).

**75.21(3) 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(4)** *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(5)** *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) or the IowaCare program in accordance with the provisions of 441—Chapter 92.

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 insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

*k.* 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.

*l.* 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).

*m.* The health plan pays secondary to another plan.

*n.* The only Medicaid members covered by the health plan are currently in foster care.

*o.* 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(6) 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(7) 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(8) 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(9) 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(10) 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(11) 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 Individual 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 and may result in Medicaid ineligibility as provided in subrule 75.21(1).

*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(16) "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(12) *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(8)) 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(13) *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 drops 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(14) *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(15) *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(16) *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(3) and 75.21(4).

**75.21(17) *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]

**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(9).

**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, 2013, through June 30, 2014, this average statewide cost shall be \$5,057.65 per month or \$166.37 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]

**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, 2013, to June 30, 2014, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is \$4,642 per month.

(2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is \$25,922 per month.

(3) The average statewide charge to a resident of a mental health institute is \$19,590 per month.

(4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$6,111 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]

**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 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]

**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 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.5(2) “d.” The classification of the debt is defined at Iowa Code section 633.425(7).

*a. Definition of 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.

*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 medical assistance 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 633.425.

(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]

**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.** In order to promote high-quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, members that utilize medical assistance services or items at a frequency or in an amount

which is considered to be overuse of services as defined in subrule 75.30(7) may be restricted (locked-in) to receive services from a designated provider(s).

**75.30(1)** A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

**75.30(2)** Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary physician(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 75.30(3).

**75.30(3)** Payment will be made to provider(s) other than the designated (lock-in) provider(s) in the following instances:

*a.* Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

*b.* The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 75.30(5).

*c.* The designated provider refers the member to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 75.30(5).

**75.30(4)** When the member fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the member.

**75.30(5)** Members may change designated provider(s) when a change is warranted, such as when the member has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the member shall make the determination when the member has demonstrated that a change is warranted. Members may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

**75.30(6)** When lock-in is imposed on a member, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

**75.30(7)** Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

*a.* Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception reporting technique to identify the members most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

*b.* In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph 75.30(7) "a," referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid member outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid members who are enrolled in the MediPASS program or a health maintenance organization or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

*c.* An investigation process of Medicaid members determined in paragraph 75.30(7) "a" or "b" to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or as consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body

of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.  
[ARC 1266C, IAB 1/8/14, effective 1/1/14]

**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



**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]

**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	\$1,950 plus \$178 for each additional person
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]

These rules are intended to implement Iowa Code section 249A.4.

[Filed 3/11/70; amended 12/17/73, 5/16/74, 7/1/74]

[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]

[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]

- [Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
- [Filed 1/31/77, Notice 12/1/76—published 2/23/77, effective 3/30/77]
- [Filed 4/13/77, Notice 11/3/76—published 5/4/77, effective 6/8/77]
- [Filed emergency 6/22/77—published 7/13/77, effective 7/1/77]
- [Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
- [Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
- [Filed emergency 7/28/78 after Notice 4/19/78—published 8/23/78, effective 7/28/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
- [Filed 6/5/79, Notice 4/4/79—published 6/27/79, effective 8/1/79]
- [Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
- [Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]
- [Filed emergency 5/5/80—published 5/28/80, effective 5/5/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed without Notice 9/25/80—published 10/15/80, effective 12/1/80]
- [Filed 12/19/80, Notice 10/15/80—published 1/7/81, effective 2/11/81]
- [Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
- [Filed 9/25/81, Notice 7/22/81—published 10/14/81, effective 11/18/81]
- [Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
- [Filed 1/28/82, Notice 12/9/81—published 2/17/82, effective 4/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed emergency 5/21/82—published 6/9/82, effective 6/1/82]
- [Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
- [Filed emergency 7/30/82—published 8/18/82, effective 8/1/82]
- [Filed 9/23/82, Notices 6/9/82, 8/4/82—published 10/13/82, effective 12/1/82]
- [Filed emergency 3/18/83—published 4/13/83, effective 4/1/83]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 9/26/83—published 10/12/83, effective 10/1/83]
- [Filed 10/28/83, Notice 9/14/83—published 11/23/83, effective 1/1/84]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
- [Filed emergency 1/13/84—published 2/1/84, effective 2/8/84]
- [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
- [Filed emergency 9/28/84—published 10/24/84, effective 10/1/84]
- [Filed emergency 1/17/85—published 2/13/85, effective 1/17/85]
- [Filed without Notice 1/22/85—published 2/13/85, effective 4/1/85]
- [Filed emergency 3/22/85—published 4/10/85, effective 4/1/85]
- [Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]
- [Filed 4/29/85, Notice 10/24/84—published 5/22/85, effective 7/1/85]
- [Filed 10/1/85, Notice 7/31/85—published 10/23/85, effective 12/1/85]
- [Filed 2/21/86, Notice 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 3/21/86 after Notice 2/12/86—published 4/9/86, effective 4/1/86]
- [Filed emergency 4/28/86—published 5/21/86, effective 5/1/86]
- [Filed emergency 8/28/86—published 9/24/86, effective 9/1/86]
- [Filed 9/5/86, Notice 6/18/86—published 9/24/86, effective 11/1/86]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed without Notice 1/15/87—published 2/11/87, effective 4/1/87]
- [Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
- [Filed 3/26/87, Notice 2/11/87—published 4/22/87, effective 6/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed emergency 5/29/87 after Notice 4/22/87—published 6/17/87, effective 7/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]

- [Filed emergency after Notice 9/24/87, Notice 8/12/87—published 10/21/87, effective 10/1/87]
  - [Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
- [Filed emergency after Notice 10/23/87, Notice 9/9/87—published 11/18/87, effective 11/1/87]
  - [Filed 10/23/87, Notice 9/9/87—published 11/18/87, effective 1/1/88]
  - [Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
    - [Filed emergency 3/16/88—published 4/6/88, effective 3/16/88]
  - [Filed 3/17/88, Notice 1/13/88—published 4/6/88, effective 6/1/88]
    - [Filed emergency 4/22/88—published 5/18/88, effective 5/1/88]
  - [Filed 4/22/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
  - [Filed 6/9/88, Notice 4/20/88—published 6/29/88, effective 9/1/88]
  - [Filed 8/4/88, Notices 6/29/88<sup>o</sup>—published 8/24/88, effective 10/1/88]
  - [Filed without Notice 9/21/88—published 10/19/88, effective 12/1/88]
  - [Filed 10/27/88, Notice 8/24/88—published 11/16/88, effective 1/1/89]
    - [Filed emergency 11/14/88—published 11/30/88, effective 11/14/88]
- [Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]
  - [Filed emergency 4/13/89 after Notice 3/8/89—published 5/3/89, effective 5/1/89]
    - [Filed 4/13/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]
    - [Filed 5/10/89, Notice 4/5/89—published 5/31/89, effective 8/1/89]
  - [Filed emergency 6/9/89 after Notice 5/3/89—published 6/28/89, effective 7/1/89]
    - [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
  - [Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
    - [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
      - [Filed emergency 10/10/89—published 11/1/89, effective 12/1/89]
    - [Filed 10/10/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
    - [Filed 12/19/89, Notice 11/1/89—published 1/10/90, effective 3/1/90]
      - [Filed emergency 1/10/90—published 2/7/90, effective 1/10/90]
    - [Filed 1/16/90, Notice 11/15/89—published 2/7/90, effective 4/1/90]
      - [Filed emergency 2/16/90—published 3/7/90, effective 4/1/90]
      - [Filed without Notice 2/16/90—published 3/7/90, effective 5/1/90]
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      - [Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
        - [Filed emergency 6/13/90—published 7/11/90, effective 6/14/90]
    - [Filed emergency 6/20/90 after Notice 4/18/90—published 7/11/90, effective 7/1/90]
      - [Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
  - [Filed emergency 8/16/90 after Notice of 6/27/90—published 9/5/90, effective 10/1/90]
    - [Filed 8/16/90, Notices 6/13/90, 7/11/90—published 9/5/90, effective 11/1/90]
      - [Filed emergency 12/13/90—published 1/9/91, effective 1/1/91]
      - [Filed 2/14/91, Notice 1/9/91—published 3/6/91, effective 5/1/91]
        - [Filed emergency 3/14/91—published 4/3/91, effective 3/14/91]
      - [Filed 3/14/91, Notice 1/23/91—published 4/3/91, effective 6/1/91]
        - [Filed emergency 4/11/91—published 5/1/91, effective 4/11/91]
      - [Filed 4/11/91, Notice 2/20/91—published 5/1/91, effective 7/1/91]
    - [Filed emergency 5/17/91 after Notice 4/3/91—published 6/12/91, effective 7/1/91]
      - [Filed 5/17/91, Notices 4/3/90<sup>o</sup>—published 6/12/91, effective 8/1/91]
    - [Filed emergency 6/14/91 after Notice 5/1/91—published 7/10/91, effective 7/1/91]
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      - [Filed emergency 12/11/91—published 1/8/92, effective 1/1/92]
  - [Filed emergency 12/11/91 after Notice 10/30/91—published 1/8/92, effective 1/1/92]

- [Filed 12/11/92, Notice 10/16/91—published 1/8/92, effective 3/1/92]<sup>1</sup>
- [Filed 1/15/92, Notice 11/13/91—published 2/5/92, effective 4/1/92]
- [Filed 2/13/92, Notices 1/8/92<sup>o</sup>—published 3/4/92, effective 5/1/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 4/16/92 after Notice 2/19/92—published 5/13/92, effective 5/1/92]
- [Filed emergency 5/14/92 after Notice 3/18/92—published 6/10/92, effective 7/1/92]
- [Filed 5/14/92, Notices 3/18/92<sup>o</sup>—published 6/10/92, effective 8/1/92]
- [Filed 6/11/92, Notice 4/29/92—published 7/8/92, effective 9/1/92]
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- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed emergency 12/1/92—published 12/23/92, effective 1/1/93]
- [Filed emergency 1/14/93 after Notice 10/28/92—published 2/3/93, effective 2/1/93]
- [Filed 1/14/93, Notices 10/28/92, 11/25/92, 12/9/92—published 2/3/93, effective 4/1/93]
- [Filed 2/10/93, Notice 12/23/92—published 3/3/93, effective 5/1/93]
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- [Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
- [Filed emergency 12/16/93—published 1/5/94, effective 1/1/94]
- [Filed without Notice 12/16/93—published 1/5/94, effective 2/9/94]
- [Filed 12/16/93, Notices 10/13/93, 10/27/93—published 1/5/94, effective 3/1/94]
- [Filed 2/10/94, Notices 12/8/93, 1/5/94<sup>o</sup>—published 3/2/94, effective 5/1/94]
- [Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
- [Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
- [Filed 5/11/94, Notice 3/16/94—published 6/8/94, effective 8/1/94]
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- [Filed emergency 12/15/94—published 1/4/95, effective 1/1/95]
- [Filed 12/15/94, Notices 10/26/94, 11/9/94—published 1/4/95, effective 3/1/95]
- [Filed 2/16/95, Notices 11/23/94, 12/21/94, 1/4/95—published 3/15/95, effective 5/1/95]
- [Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
- [Filed emergency 9/25/95—published 10/11/95, effective 10/1/95]
- [Filed 11/16/95, Notices 9/27/95, 10/11/95—published 12/6/95, effective 2/1/96]
- [Filed emergency 12/12/95—published 1/3/96, effective 1/1/96]
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- [Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]<sup>o</sup>
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- [Filed emergency 12/10/97—published 12/31/97, effective 1/1/98]
- [Filed emergency 12/10/97 after Notices 10/22/97, 11/5/97—published 12/31/97, effective 1/1/98]
- [Filed emergency 1/14/98 after Notice 11/19/97—published 2/11/98, effective 2/1/98]
- [Filed 2/11/98, Notice 12/31/97—published 3/11/98, effective 5/1/98]<sup>◇</sup>
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- [Filed 11/8/00, Notice 10/4/00—published 11/29/00, effective 1/3/01]
- [Filed emergency 12/14/00—published 1/10/01, effective 1/1/01]
- [Filed 2/14/01, Notice 1/10/01—published 3/7/01, effective 5/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>◇</sup>
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]<sup>◇</sup>
- [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]
- [Filed emergency 12/12/01—published 1/9/02, effective 1/1/02]
- [Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02]
- [Filed 2/14/02, Notice 12/26/01—published 3/6/02, effective 5/1/02]
- [Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
- [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]<sup>◇</sup>
- [Filed emergency 6/13/02—published 7/10/02, effective 7/1/02]
- [Filed 10/10/02, Notice 8/21/02—published 10/30/02, effective 1/1/03]
- [Filed emergency 12/12/02—published 1/8/03, effective 1/1/03]<sup>◇</sup>
- [Filed emergency 1/9/03 after Notice 11/27/02—published 2/5/03, effective 2/1/03]
- [Filed 1/9/03, Notice 11/27/02—published 2/5/03, effective 4/1/03]

- [Filed emergency 3/14/03—published 4/2/03, effective 4/1/03]
- [Filed without Notice 5/16/03—published 6/11/03, effective 7/16/03]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
- [Filed emergency 10/10/03—published 10/29/03, effective 10/10/03]
- [Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
- [Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
- [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
- [Filed emergency 3/11/04—published 3/31/04, effective 4/1/04]
- [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
- [Filed emergency 9/23/04 after Notice 7/7/04—published 10/13/04, effective 10/1/04]
- [Filed 10/8/04, Notice 7/7/04—published 10/27/04, effective 12/1/04]
- [Filed 10/14/04, Notice 8/4/04—published 11/10/04, effective 1/1/05]
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- [Filed emergency 7/15/05 after Notice 5/11/05—published 8/3/05, effective 8/1/05]
- [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
- [Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
- [Filed emergency 12/14/05—published 1/4/06, effective 1/1/06]
- [Filed emergency 1/12/06 after Notice 11/23/05—published 2/1/06, effective 2/1/06]
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- [Filed 11/8/06, Notice 7/5/06—published 12/6/06, effective 1/10/07]
- [Filed 12/13/06, Notice 7/5/06—published 1/3/07, effective 2/7/07]
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- [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]◊
- [Filed emergency 10/10/07 after Notice 8/29/07—published 11/7/07, effective 11/1/07]
- [Filed 12/12/07, Notice 7/4/07—published 1/2/08, effective 2/6/08]◊
- [Filed emergency 1/9/08 after Notice 12/5/07—published 1/30/08, effective 2/1/08]
- [Filed emergency 2/13/08 after Notice 12/19/07—published 3/12/08, effective 2/15/08]
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- [Filed emergency 10/14/08 after Notice 8/27/08—published 11/5/08, effective 11/1/08]
- [Filed emergency 11/12/08 after Notice 9/24/08—published 12/3/08, effective 1/1/09]

- [Filed 11/12/08, Notice 8/13/08—published 12/3/08, effective 2/1/09]  
[Filed ARC 7546B (Notice ARC 7356B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]  
[Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]  
[Filed ARC 7834B (Notice ARC 7630B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]  
[Filed ARC 7833B (Notice ARC 7629B, IAB 3/11/09), IAB 6/3/09, effective 8/1/09]  
[Filed Emergency ARC 7929B, IAB 7/1/09, effective 7/1/09]  
[Filed Emergency ARC 7931B, IAB 7/1/09, effective 7/1/09]  
[Filed Emergency ARC 7932B, IAB 7/1/09, effective 7/1/09]  
[Filed ARC 7935B (Notice ARC 7718B, IAB 4/22/09), IAB 7/1/09, effective 9/1/09]  
[Filed ARC 8095B (Notice ARC 7930B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]  
[Filed ARC 8096B (Notice ARC 7934B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]  
[Filed ARC 8260B (Notice ARC 8056B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]  
[Filed Emergency After Notice ARC 8261B, IAB 11/4/09, effective 10/15/09]  
[Filed ARC 8439B (Notice ARC 8083B, IAB 8/26/09), IAB 1/13/10, effective 3/1/10]  
[Filed ARC 8443B (Notice ARC 8220B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]  
[Filed ARC 8444B (Notice ARC 8221B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]  
[Filed Emergency After Notice ARC 8503B (Notice ARC 8311B, IAB 11/18/09), IAB 2/10/10,  
effective 1/13/10]  
[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10,  
effective 3/1/10]  
[Filed Emergency After Notice ARC 8556B (Notice ARC 8407B, IAB 12/16/09), IAB 3/10/10,  
effective 2/10/10]  
[Filed ARC 8642B (Notice ARC 8461B, IAB 1/13/10), IAB 4/7/10, effective 6/1/10]  
[Filed Without Notice ARC 8713B, IAB 5/5/10, effective 8/1/10]  
[Filed Emergency After Notice ARC 8786B (Notice ARC 8552B, IAB 2/24/10), IAB 6/2/10, effective  
6/1/10]  
[Filed ARC 8785B (Notice ARC 8619B, IAB 3/24/10), IAB 6/2/10, effective 8/1/10]  
[Filed Emergency ARC 8898B, IAB 6/30/10, effective 7/1/10]  
[Filed ARC 8897B (Notice ARC 8705B, IAB 4/21/10), IAB 6/30/10, effective 9/1/10]  
[Filed ARC 9043B (Notice ARC 8853B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]  
[Filed ARC 9044B (Notice ARC 8864B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]  
[Filed ARC 9404B (Notice ARC 9277B, IAB 12/15/10), IAB 3/9/11, effective 5/1/11]  
[Filed ARC 9439B (Notice ARC 9309B, IAB 12/29/10), IAB 4/6/11, effective 6/1/11]  
[Filed Emergency ARC 9582B, IAB 6/29/11, effective 7/1/11]  
[Filed ARC 9581B (Notice ARC 9479B, IAB 4/20/11), IAB 6/29/11, effective 8/3/11]  
[Filed Emergency ARC 9647B, IAB 8/10/11, effective 8/1/11]  
[Filed Emergency ARC 9696B, IAB 9/7/11, effective 9/1/11]  
[Filed ARC 9881B (Notice ARC 9697B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed Emergency After Notice ARC 9956B (Notice ARC 9648B, IAB 8/10/11), IAB 1/11/12, effective  
1/1/12]  
[Filed Emergency After Notice ARC 9957B (Notice ARC 9804B, IAB 10/19/11), IAB 1/11/12,  
effective 1/1/12]  
[Filed ARC 0149C (Notice ARC 0047C, IAB 3/21/12), IAB 6/13/12, effective 8/1/12]  
[Filed Emergency ARC 0192C, IAB 7/11/12, effective 7/1/12]  
[Filed ARC 0579C (Notice ARC 0432C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]  
[Filed Emergency After Notice ARC 0822C (Notice ARC 0690C, IAB 4/17/13), IAB 7/10/13,  
effective 7/1/13]  
[Filed Emergency After Notice ARC 0821C (Notice ARC 0691C, IAB 4/17/13), IAB 7/10/13,  
effective 7/1/13]  
[Filed Emergency After Notice ARC 0820C (Notice ARC 0668C, IAB 4/3/13), IAB 7/10/13, effective  
8/1/13]  
[Filed ARC 0990C (Notice ARC 0746C, IAB 5/15/13), IAB 9/4/13, effective 1/1/14]

[Filed Emergency After Notice ARC 1134C (Notice ARC 0971C, IAB 8/21/13), IAB 10/30/13,  
effective 10/2/13]

[Filed Emergency ARC 1212C, IAB 12/11/13, effective 1/1/14]

[Filed Emergency ARC 1266C, IAB 1/8/14, effective 1/1/14]

<sup>0</sup> 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 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 Iowa Foundation for Medical Care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

*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 Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility

in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The "Preprocedure Surgical Review List" shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the "Preprocedure Surgical Review List" annually. (Cross-reference 78.28(1) "e.")

**78.1(20) Transplants.**

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lymphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin's lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.

(4) Liver transplants for persons with extrahepatic biliary arsesia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.")

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

*b.* Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

*c.* All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

*d.* Payment will not be made for any transplant not specifically listed in paragraph “*a.*”

**78.1(21)** Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.1(22)** Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

*a.* If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

*b.* If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

**78.1(23)** EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

**78.1(24)** Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

*a.* Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

*b.* Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

*c.* Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

*d.* Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8714B, IAB 5/5/10, effective 5/1/10; 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]

**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.*** 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.

**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]

**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 IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)“f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)“f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

**78.3(14)** Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)“f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)“f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

**78.3(15)** Payment for inpatient hospital charges associated with surgical procedures on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital's utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.”

**78.3(16)** 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 IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

**78.3(19)** Rescinded IAB 10/8/97, effective 12/1/97.

This rule is intended to implement Iowa Code section 249A.4.

[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]

**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. Salzmann, 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-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		
		723.5	Torticollis, unspecified		
		724.01	Spinal stenosis, thoracic region		
		724.02	Spinal stenosis, lumbar region		
		724.4	Thoracic or lumbosacral neuritis or radiculitis		
		724.6	Disorders of sacrum, ankylosis		
		724.79	Disorders of coccyx, coccygodynia		

ICD-9 CATEGORY I	ICD-9 CATEGORY II	ICD-9 CATEGORY III
	724.8 Other symptoms referable to back, facet syndrome	
	729.1 Myalgia and myositis, unspecified	
	729.4 Fascitis, unspecified	
	738.40 Acquired spondylolisthesis	
	756.12 Spondylolisthesis	
	846.0 Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)	
	846.1 Sprains and strains of sacroiliac region, sacroiliac ligament	
	846.2 Sprains and strains of sacroiliac region, sacrospinatus (ligament)	
	846.3 Sprains and strains of sacroiliac region, sacrotuberous (ligament)	
	846.8 Sprains and strains of sacroiliac region, other specified sites of sacroiliac region	
	847.0 Sprains and strains, neck	
	847.1 Sprains and strains, thoracic	
	847.2 Sprains and strains, lumbar	
	847.3 Sprains and strains, sacrum	
	847.4 Sprains and strains, coccyx	

b. The neuromusculoskeletal conditions listed in the table in paragraph “a” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

**78.8(3) Documenting X-ray.** An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “c” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph "a" of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph "a" of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.9(249A) Home health agencies.** Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) "a" may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

**78.9(1) Treatment plan.** A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
  - (1) Dates of prior hospitalization.
  - (2) Dates of prior surgery.
  - (3) Date last seen by a physician.
  - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
  - (5) Prognosis.
  - (6) Functional limitations.
  - (7) Vital signs reading.
  - (8) Date of last episode of instability.
  - (9) Date of last episode of acute recurrence of illness or symptoms.
  - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 62 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's signature and date. The 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 an Axis I psychological disorder, subject to the limitations in this rule.

**78.12(1) Definitions.**

“*Axis I disorder*” means a diagnosed mental disorder, except for personality disorders and mental retardation, as set forth in the “Diagnostic and Statistical Manual IV-TR,” Fourth Edition.

“*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 Axis I 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.), 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:

1. Is licensed by the applicable state authority for that profession;
2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and
3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

**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 provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

*c.* For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment 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 an Axis I 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]

**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, the member 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 needs make 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 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.

*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.

**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]

**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 Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8205B, IAB 10/7/09, effective 11/11/09]

**441—78.27(249A) Home- and community-based habilitation services.** Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Plan for Behavioral Health.

**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.

“*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 Iowa Medicaid enterprise medical services unit or the Iowa Plan for Behavioral Health contractor has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service. 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 or the Iowa Plan for Behavioral Health contractor has approved the member's 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 or in a treatment plan that has been authorized by the Iowa Plan for Behavioral Health contractor 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).

*f. Iowa Plan for Behavioral Health eligibility.* Members eligible to enroll in the Iowa Plan for Behavioral Health shall be eligible to receive home- and community-based habilitation services only through the Iowa Plan for Behavioral Health.

**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 Iowa Plan for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason. The department or the Iowa Plan for Behavioral Health contractor shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the comprehensive service plan or treatment plan have been completed.

**78.27(4) Comprehensive service plan.** Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan 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 Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system 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 Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system 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.*

(1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.

(2) For members who are not Iowa Plan-eligible, 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 or the Iowa Plan for Behavioral Health contractor 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 or the Iowa Plan for Behavioral Health contractor 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 or the Iowa Plan for Behavioral Health contractor 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 or the Iowa Plan for Behavioral Health contractor 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.*

(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.

(2) 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]

**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 Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The “Preprocedure Surgical Review List” shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

*g.* 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) Interceptive 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 preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

**78.28(6)** Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

**78.28(7)** 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)** Rescinded IAB 1/3/96, effective 3/1/96.

**78.28(9)** Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance

with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

*b. Requirements.*

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

**78.28(10)** Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3) "b")

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; 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]

**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 Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a.* Emergency service.
- b.* Outpatient surgery.
- c.* Laboratory, X-ray and other diagnostic services.
- d.* General or family medicine.
- e.* Follow-up or after-care specialty clinics.
- f.* Physical medicine and rehabilitation.
- g.* Alcoholism and substance abuse.
- h.* Eating disorders.
- i.* Cardiac rehabilitation.
- j.* Mental health.
- k.* Pain management.
- l.* Diabetic education.
- m.* Pulmonary rehabilitation.
- n.* Nutritional counseling for persons aged 20 and under.

**78.31(2) Requirements for all outpatient services.**

*a. Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

*b. Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

*c. Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

*d. Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

*e. Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

*f. Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

*g. Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

*h. 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, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

*c.* Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac 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, dysrhythmia 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]

**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.**

**78.33(1)** Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

*a.* Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

*b.* Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

**78.33(2)** Notwithstanding subrule 78.33(1), payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.

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]

**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.* 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.

*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.
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.

**78.34(11) *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 that 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.

**78.34(12) *Nutritional counseling.*** Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

**78.34(13) *Consumer choices option.*** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

*a. Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

*b. Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13) "b"(2) or the utilization adjustment factor in subparagraph 78.34(13) "b"(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

*c. Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

*d. Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

*e. Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)“d.” The savings plan shall meet the requirements in paragraph 78.34(13)“f.”

*f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member’s identified service needs.

4. How the member’s assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member’s identified need,
2. Be medically necessary, and
3. Be approved by the member’s case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member’s needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

*g. Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law

employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

**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]

**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, to receive medical services when not reimbursed through nonemergency medical transportation, 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.* 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.

(5) 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.

*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).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.37(17) Case management services.** Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

*a.* Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

*b.* Case management shall not include the provision of direct services by the case managers.

*c.* Payment for case management shall not be made until the consumer is enrolled in the waiver.

Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

**78.37(18) Assisted living on-call service.** The assisted living on-call service provides staff on call 24 hours per day to meet a member's scheduled, unscheduled, and unpredictable needs in a manner that promotes maximum dignity and independence and provides safety and security. A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day.

**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]

**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.* 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.

*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).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.38(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]

**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.

(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.* 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.

*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 receive medical services when not reimbursed through nonemergency medical transportation, 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 rehabilitative goals, and are reflected in a rehabilitative plan that focuses on general rehabilitative 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).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.41(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]

**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 service excludes transportation to and from work or day programs.

(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 receive medical services when not reimbursed through nonemergency medical transportation, 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.* 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.

*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).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.43(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]

**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 DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance 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]

**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.* 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.

*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 receive medical services when not reimbursed through nonemergency medical transportation, 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).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

**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]

**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]

[Filed 3/11/70; amended 3/20/74]

- [Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]
- [Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]
- [Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]
- [Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]
- [Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]
- [Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]
- [Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
- [Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]
- [Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]
- [Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]
- [Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]
- [Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]
- [Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]
- [Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]
- [Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
- [Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
- [Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
- [Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
- [Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]
- [Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]
- [Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]
- [Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]
- [Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]
- [Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
- [Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]
- [Filed 1/4/79, Notice 11/29/78—published 1/24/79, effective 3/1/79]
- [Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]
- [Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 6/1/79]

- [Filed 7/3/79, Notice 4/18/79—published 7/25/79, effective 8/29/79]
- [Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
- [Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79]
- [Filed emergency 9/6/79 after Notice 7/11/79—published 10/3/79, effective 10/1/79]
- [Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
- [Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
- [Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
- [Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
- [Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
- [Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
- [Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
- [Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
- [Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
- [Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
- [Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
- [Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
- [Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
- [Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
- [Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]
- [Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
- [Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
- [Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
- [Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
- [Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
- [Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
- [Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
- [Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
- [Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notices 3/30/83, 4/13/83—published 6/8/83, effective 8/1/83]<sup>◇</sup>
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 7/29/83—published 8/17/83, effective 8/1/83]<sup>◇</sup>
- [Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]
- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84]<sup>◇</sup>
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
- [Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
- [Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
- [Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
- [Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]

- [Filed emergency 8/23/85—published 9/11/85, effective 9/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 10/18/85 after Notice 9/11/85—published 11/6/85, effective 11/1/85]
- [Filed 11/15/85, Notice 9/25/85—published 12/4/85, effective 2/1/86]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/1/86, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
- [Filed emergency 12/22/86—published 1/14/87, effective 2/1/87]
- [Filed 12/22/86, Notice 11/5/86—published 1/14/87, effective 3/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notices 12/17/86, 12/31/86, 1/14/87—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed 5/29/87, Notices 4/8/87, 4/22/87—published 6/17/87, effective 8/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 6/19/87, Notice 5/6/87—published 7/15/87, effective 9/1/87]
- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 8/28/87, Notices 6/17/87, 7/15/87—published 9/23/87, effective 11/1/87]
- [Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
- [Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
- [Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed 10/11/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
- [Filed 11/16/89, Notice 8/23/89—published 12/13/89, effective 2/1/90]
- [Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90<sup>2</sup>]
- [Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
- [Filed 3/16/90, Notices 11/15/89, 1/24/90, 2/7/90—published 4/4/90, effective 6/1/90]
- [Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notices 5/16/90, 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
- [Filed 9/28/90, Notices 7/11/90, 7/25/90, 8/8/90—published 10/17/90, effective 12/1/90]
- [Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed 11/16/90, Notices 9/19/90, 10/3/90—published 12/12/90, effective 2/1/91]

- [Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91<sup>3</sup>]
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notice 3/20/91—published 7/10/91, effective 9/1/91]
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92<sup>4</sup>]
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
- [Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]
- [Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92<sup>o</sup>]
- [Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]
- [Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]
- [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 9/11/92, Notices 7/8/92, 8/5/92—published 9/30/92, effective 12/1/92]
- [Filed 9/11/92, Notice 8/5/92—published 9/30/92, effective 1/1/93]
- [Filed 10/15/92, Notices 8/19/92, 9/2/92—published 11/11/92, effective 1/1/93]
- [Filed emergency 11/10/92—published 12/9/92, effective 11/10/92]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed 1/14/93, Notices 10/28/92, 11/25/92—published 2/3/93, effective 4/1/93]
- [Filed emergency 4/15/93 after Notice 3/3/93—published 5/12/93, effective 5/1/93]
- [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
- [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
- [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
- [Filed emergency 7/14/93—published 8/4/93, effective 8/1/93]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed 9/17/93, Notice 8/4/93—published 10/13/93, effective 12/1/93]
- [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
- [Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
- [Filed emergency 12/16/93 after Notice 10/13/93—published 1/5/94, effective 1/1/94]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
- [Filed emergency 2/10/94 after Notice 12/22/93—published 3/2/94, effective 3/1/94]
- [Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 8/12/94, Notice 6/22/94—published 8/31/94, effective 11/1/94]
- [Filed 9/15/94, Notices 7/6/94, 8/3/94—published 10/12/94, effective 12/1/94]
- [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
- [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/5/95]
- [Filed 5/11/95, Notices 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]

- [Filed 6/14/95, Notice 5/10/95—published 7/5/95, effective 9/1/95]
- [Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]
- [Filed 11/16/95, Notices 8/2/95, 9/27/95<sup>o</sup>—published 12/6/95, effective 2/1/96]
- [Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
- [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
- [Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
- [Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
- [Filed 1/15/97, Notice 12/4/96—published 2/12/97, effective 4/1/97]
- [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
- [Filed 7/9/97, Notice 5/21/97—published 7/30/97, effective 10/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 1/14/98, Notice 11/19/97—published 2/11/98, effective 4/1/98]
- [Filed 4/8/98, Notices 2/11/98, 2/25/98—published 5/6/98, effective 7/1/98]
- [Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]
- [Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
- [Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
- [Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 3/1/99]
- [Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
- [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
- [Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 6/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
- [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 10/13/99, Notice 6/30/99—published 11/3/99, effective 1/1/00]
- [Filed 4/12/00, Notice 2/23/00—published 5/3/00, effective 7/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed 6/8/00, Notices 1/26/00, 4/19/00—published 6/28/00, effective 9/1/00]
- [Filed 8/9/00, Notices 6/14/00, 6/28/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
- [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [Filed 10/11/00, Notice 4/19/00—published 11/1/00, effective 1/1/01]
- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
- [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
- [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
- [Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 7/4/01]
- [Filed 5/9/01, Notices 1/24/01, 3/7/01—published 5/30/01, effective 8/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>o</sup>
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 11/14/01, Notices 9/19/01, 10/3/01—published 12/12/01, effective 2/1/02]

- [Filed emergency 12/12/01 after Notice 10/17/01—published 1/9/02, effective 12/12/01]
  - [Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
  - [Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]<sup>◊</sup>
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]<sup>◊</sup>
  - [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02<sup>5</sup>]
  - [Filed emergency 2/14/02—published 3/6/02, effective 3/1/02]
  - [Filed 3/13/02, Notice 1/9/02—published 4/3/02, effective 6/1/02]
  - [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
  - [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
  - [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
  - [Filed 4/10/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
  - [Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
  - [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
  - [Filed emergency 8/15/02—published 9/4/02, effective 9/1/02]
  - [Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
  - [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
  - [Filed emergency 11/18/02—published 12/11/02, effective 12/15/02]<sup>6</sup>
  - [Filed 11/18/02, Notice 9/4/02—published 12/11/02, effective 2/1/03]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
  - [Filed 12/12/02, Notice 10/30/02—published 1/8/03, effective 3/1/03]
  - [Filed emergency 1/9/03—published 2/5/03, effective 2/1/03]<sup>◊</sup>
  - [Filed 2/13/03, Notice 11/27/02—published 3/5/03, effective 5/1/03]
  - [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
  - [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]<sup>◊</sup>
  - [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]<sup>◊</sup>
  - [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
- [Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]
  - [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
  - [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]<sup>◊</sup>
  - [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
  - [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
  - [Filed 7/15/05, Notice 5/25/05—published 8/3/05, effective 10/1/05]
  - [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
  - [Filed emergency 10/21/05—published 11/9/05, effective 11/1/05]
- [Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]<sup>◊</sup>
  - [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
  - [Filed 1/12/06, Notice 11/9/05—published 2/1/06, effective 3/8/06]
  - [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
  - [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
  - [Filed 5/12/06, Notice 3/15/06—published 6/7/06, effective 8/1/06]
  - [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
  - [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
  - [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
  - [Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
  - [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
- [Filed emergency 3/14/07 after Notice 1/17/07—published 4/11/07, effective 4/1/07]
  - [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
  - [Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]

- [Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]
  - [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
  - [Filed without Notice 7/20/07—published 8/15/07, effective 10/1/07]
  - [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
- [Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]
- [Filed emergency 1/9/08 after Notice 10/10/07—published 1/30/08, effective 2/1/08]
  - [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 5/15/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
- [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
  - [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
  - [Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]
  - [Filed emergency 8/18/08—published 9/10/08, effective 9/1/08]
- [Filed emergency 8/18/08 after Notice 7/2/08—published 9/10/08, effective 10/1/08]
  - [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
- [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
  - [Filed 10/14/08, Notice 8/13/08—published 11/5/08, effective 1/1/09]
- [Filed emergency 11/12/08 after Notice 9/10/08—published 12/3/08, effective 12/1/08]
  - [Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]
  - [Filed 12/11/08, Notice 9/10/08—published 1/14/09, effective 2/18/09]
  - [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
- [Filed ARC 7548B (Notice ARC 7369B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
- [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]<sup>7</sup>
- [Filed Emergency After Notice ARC 8008B (Notice ARC 7771B, IAB 5/20/09), IAB 7/29/09, effective 8/1/09]
  - [Filed ARC 8097B (Notice ARC 7816B, IAB 6/3/09), IAB 9/9/09, effective 11/1/09]
  - [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
    - [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
  - [Filed ARC 8504B (Notice ARC 8247B, IAB 10/21/09), IAB 2/10/10, effective 3/22/10]
- [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
- [Filed Emergency After Notice ARC 8714B (Notice ARC 8538B, IAB 2/24/10), IAB 5/5/10, effective 5/1/10]
  - [Filed ARC 8993B (Notice ARC 8722B, IAB 5/5/10), IAB 8/11/10, effective 10/1/10]
  - [Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
  - [Filed ARC 9045B (Notice ARC 8832B, IAB 6/2/10), IAB 9/8/10, effective 11/1/10]
    - [Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
  - [Filed ARC 9175B (Notice ARC 8975B, IAB 7/28/10), IAB 11/3/10, effective 1/1/11]
    - [Filed Emergency ARC 9256B, IAB 12/1/10, effective 1/1/11]
    - [Filed Emergency ARC 9311B, IAB 12/29/10, effective 1/1/11]
  - [Filed ARC 9315B (Notice ARC 9111B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
  - [Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
  - [Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]<sup>8</sup>
- [Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
  - [Editorial change: IAC Supplement 4/20/11]
  - [Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
- [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]
- [Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective 8/1/11]

- [Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]  
 [Filed Emergency ARC 9699B, IAB 9/7/11, effective 9/1/11]  
 [Filed Emergency ARC 9702B, IAB 9/7/11, effective 9/1/11]  
 [Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]  
 [Filed Emergency ARC 9834B, IAB 11/2/11, effective 11/1/11]  
 [Filed ARC 9882B (Notice ARC 9700B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
 [Filed ARC 9883B (Notice ARC 9703B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
 [Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
 [Filed ARC 9981B (Notice ARC 9835B, IAB 11/2/11), IAB 2/8/12, effective 3/14/12]  
 [Filed ARC 0065C (Notice ARC 9940B, IAB 12/28/11), IAB 4/4/12, effective 6/1/12]  
 [Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]  
 [Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]  
 [Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]  
 [Filed ARC 0305C (Notice ARC 0144C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]  
 [Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]  
 [Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
 [Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
 [Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
 [Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]  
 [Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]  
 [Filed ARC 0631C (Notice ARC 0497C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]  
 [Filed ARC 0632C (Notice ARC 0496C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]  
 [Filed ARC 0707C (Notice ARC 0567C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]  
 [Filed ARC 0709C (Notice ARC 0589C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]  
 [Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]  
 [Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]  
 [Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]  
 [Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]  
 [Filed Emergency ARC 0844C, IAB 7/24/13, effective 7/1/13]  
 [Filed Emergency ARC 0846C, IAB 7/24/13, effective 7/1/13]  
 [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]  
 [Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]  
 [Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]  
 [Filed ARC 1052C (Notice ARC 0845C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1054C (Notice ARC 0843C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1151C (Notice ARC 0920C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]  
 [Filed ARC 1264C (Notice ARC 1161C, IAB 10/30/13), IAB 1/8/14, effective 3/1/14]

◇ 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 86  
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program and establish requirements for the third-party administrator responsible for the program administration and for the participating health and dental plans that will be delivering services to the enrollees. The purpose of this program is to provide transitional health and dental care coverage to children who are ineligible for Title XIX (Medicaid) assistance as set forth in this chapter. This chapter shall be construed to comply with all requirements for federal funding under Title XXI of the Social Security Act or under the terms of any applicable waiver of Title XXI 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 XXI or the terms of any applicable waiver, the requirements of Title XXI or the terms of the waiver shall prevail.

[ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14]

**441—86.1(514I) Definitions.**

*“Applicant”* shall mean anyone in the household, including all adults and children under the age of 19 who are counted in the HAWK-I family size according to the modified adjusted gross income methodology and who are listed on the application or renewal form.

*“Benchmark benefit package for health care coverage”* shall mean any of the following:

1. The standard Blue Cross Blue Shield preferred provider option service benefit plan, described in and offered under 5 U.S.C. Section 8903(1).

2. A health benefits coverage plan that is offered and generally available to state employees in this state.

3. The plan of a health maintenance organization, as defined in 42 U.S.C. Section 300e, with the largest insured commercial, nonmedical assistance enrollment of covered lives in the state.

*“Capitation rate”* shall mean the fee the department pays monthly to a participating health or dental plan for each enrollee for the provision of covered medical or dental services whether or not the enrollee received services during the month for which the fee is intended.

*“Contract”* shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health or dental plan for the provision of medical or dental services to HAWK-I enrollees for whom the participating health or dental plans assume risk.

*“Cost sharing”* shall mean the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act and Iowa Code section 514I.10.

*“Countable income”* shall mean earned and unearned income of the family according to the modified adjusted gross income methodology.

*“Covered services”* shall mean all or a part of those medical and dental services set forth in rule 441—86.14(514I).

*“Dentist”* shall mean a person who is licensed to practice dentistry.

*“Department”* shall mean the Iowa department of human services.

*“Director”* shall mean the director of the Iowa department of human services.

*“Eligible child”* shall mean an individual who meets the criteria for participation in the HAWK-I program as set forth in rule 441—86.2(514I).

*“Emergency dental condition”* shall mean an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

*“Emergency medical condition”* shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such 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 one of the following:

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

*“Emergency services”* shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical or dental condition.

*“Enrollee”* shall mean a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

*“Family”* shall mean anyone in the household, including all adults and children under the age of 19 who are counted in the HAWK-I family size according to the modified adjusted gross income methodology.

*“Federal poverty level”* shall mean the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

*“Good cause”* shall mean the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee’s control.
4. There was a failure to receive the third-party administrator’s request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

*“HAWK-I board”* or *“board”* shall mean the entity that adopts rules, establishes policy, and directs the department regarding the HAWK-I program.

*“HAWK-I program”* or *“program”* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

*“Health insurance coverage”* shall mean health insurance coverage as defined in 45 CFR Section 144.103, as amended to October 1, 2008.

*“Health Insurance Marketplace”* or *“Exchange”* shall mean the entity authorized under 42 U.S.C. Section 18031(d)(4)(F) as amended to April 1, 2013, to evaluate and determine eligibility of applicants for Medicaid, the Children’s Health Insurance Program (CHIP), and other health programs.

*“Institution for mental diseases”* shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

*“Modified adjusted gross income”* shall mean the methodology prescribed in 42 U.S.C. Section 1396a(e)(14) and 42 CFR 435.603 as amended to April 1, 2013.

*“Nonmedical public institution”* shall mean an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined in 42 CFR Section 435.1009 as amended November 10, 1994.

*“Participating dental plan”* shall mean any entity licensed by the division of insurance of the department of commerce to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

*“Participating health plan”* shall mean any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

*“Physician”* shall be defined as provided in Iowa Code subsection 135.1(4).

*“Provider”* shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the HAWK-I program.

“*Third-party administrator*” shall mean the person or entity with which the department contracts to provide administrative services for the HAWK-I program.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8580B, IAB 3/10/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.2(514I) Eligibility factors.** The decision with respect to eligibility shall be based primarily on electronic data matches and information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the HAWK-I program.

**86.2(1) Age.** The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child’s nineteenth birthday.

**86.2(2) Income.**

*a. Countable income.* In determining initial and ongoing eligibility for the HAWK-I program, countable income shall not exceed 302 percent of the federal poverty level for a family of the same size. Countable income shall be determined using the modified adjusted gross income methodology.

*b. Verification of income.* Income shall be verified through electronic data matches when possible or otherwise verified using the best information available.

(1) Pay stubs, tip records, tax records and employers’ statements are acceptable forms of verification of earned income.

(2) If self-employment income cannot be verified through electronic means, business records or income tax returns from the previous year can be used if they are representative of anticipated earnings. If business records or tax returns from the previous year are not representative of anticipated earnings, an average of the business records or tax returns from the previous two or three years may be used if that average is representative of anticipated earnings.

*c. Changes in income.* Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child’s eligibility to participate in the HAWK-I program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

**86.2(3) Family size.** For purposes of establishing initial and ongoing eligibility under the HAWK-I program, the family size shall be determined according to the modified adjusted gross income methodology.

**86.2(4) Uninsured status.** The child must be uninsured.

*a.* A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program. However, a child who is enrolled in a plan shall not be considered insured for purposes of the HAWK-I program if:

(1) The plan provides coverage only for a specific disease or service (such as a vision, dental, or cancer policy), or

(2) The child does not have reasonable geographic access to care under that plan. “Reasonable geographic access” means that the plan or an option available under the plan does not have service area limitations or, if the plan has service area limitations, the child lives within 30 miles or 30 minutes of a network primary care provider, or

(3) The child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology. If a child loses eligibility because of such loss of income disregards, the child may be covered under the HAWK-I program for up to 12 months following the loss of Medicaid eligibility regardless of the presence of other health insurance.

*b.* A child whose health insurance ends in the month of application shall be considered uninsured for purposes of HAWK-I eligibility. However, a one-month waiting period may be imposed pursuant to subrule 86.5(1) for a child who is subject to a monthly premium pursuant to paragraph 86.8(2) “c.”

*c.* American Indian and Alaska Native. American Indian and Alaska Native children are eligible for the HAWK-I program on the same basis as other children in the state, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care.

**86.2(5) *Ineligibility for Medicaid.*** The child shall not be receiving Medicaid or eligible to receive Medicaid except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

**86.2(6) *Iowa residency.*** Residency in Iowa is a condition of eligibility for the HAWK-I program. Residency shall be established in accordance with rule 441—75.10(249A).

**86.2(7) *Citizenship and immigration status.*** To be eligible for the HAWK-I program, the child shall be a citizen or lawfully admitted immigrant. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted immigrant child is eligible to participate in the HAWK-I program.

*a.* The citizenship or immigration status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

*b.* As a condition of eligibility for HAWK-I:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration.

(2) When a child under the age of 19 is not living independently, the child's parent or other responsible person with whom the child lives shall be responsible for attesting to the child's citizenship or immigration status and for providing any required proof of the status.

*c.* Except as provided in 441—paragraph 75.11(2)“*f*,” applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7)“*b*” shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2)“*d*,” “*e*,” “*g*,” “*h*,” and “*i*.”

*d.* An applicant or enrollee shall have a reasonable opportunity period to obtain and provide proof of citizenship and nationality in accordance with 441—paragraph 75.11(2)“*c*.”

*e.* Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

**86.2(8) *Dependents of state of Iowa employees.*** The child shall not be eligible for the HAWK-I program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. “Nominal amount” shall mean \$10 or less per month.

**86.2(9) *Inmates of nonmedical public institutions.*** The child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

**86.2(10) *Inmates of institutions for mental disease.*** At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

**86.2(11) *Furnishing a social security number.*** As a condition of eligibility and in accordance with rule 441—75.7(249A), a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under HAWK-I is being requested or received.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 7881B, IAB 7/1/09, effective 7/1/09; ARC 8109B, IAB 9/9/09, effective 10/14/09; ARC 8127B, IAB 9/9/09, effective 9/1/09; ARC 8280B, IAB 11/18/09, effective 1/1/10; ARC 8281B, IAB 11/18/09, effective 12/23/09; ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8838B, IAB 6/16/10, effective 6/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14]

#### **441—86.3(514I) Application process.**

**86.3(1) *Who may apply.*** Each person wishing to do so shall have the opportunity to apply for the HAWK-I program in accordance with rule 441—76.1(249A).

**86.3(2) *Applications.*** An application for the HAWK-I program shall be filed in accordance with rule 441—76.1(249A).

**86.3(3) *Place of filing.*** An application for the HAWK-I program may be filed with the third-party administrator responsible for making the eligibility determination through an Internet Web site, by telephone, through other electronic means, or in any local or area office of the department of human services, an exchange, disproportionate share hospital, federally qualified health center, or other facility in which outstationing activities are provided.

**86.3(4)** *Date and method of filing.* The application is considered filed when received in accordance with rule 441—76.1(249A).

**86.3(5)** *Right to withdraw application.* After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application shall be documented, and the applicant shall be sent a notice of decision confirming the request.

**86.3(6)** *Application not required.*

*a.* An application shall not be required when a child becomes ineligible for Medicaid.

*b.* A new application shall not be required when an eligible child is added to an existing HAWK-I eligible group.

*c.* A new application shall not be required when a child moves between supplemental dental-only coverage as specified in rule 441—86.20(514I) and full medical and dental coverage.

**86.3(7)** *Information and verification procedure.* The decision with respect to eligibility shall be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee and verified through electronic data matches whenever possible.

*a.* The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall be notified in writing of additional information or verification that is required to establish eligibility. The notice may be provided personally, by U.S. mail, by e-mail, or by facsimile.

*b.* Failure to supply the information or verification or refusal to authorize the third-party administrator to secure the information shall serve as a basis for rejection of the application or cancellation of coverage. If the requested information or authorization is received within 14 calendar days of the notice of decision on an application or within 14 calendar days of the effective date of cancellation for enrollees, the information or authorization shall be acted upon as though it had been provided timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or enrollee shall have until the next business day to provide the information.

*c.* The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall have 10 working days to supply the information or verification requested. The due date may be extended for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

**86.3(8)** *Time limit for decision.* Decisions regarding the applicant's eligibility to participate in the HAWK-I program shall be made within ten working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department or third-party administrator. Day one of the ten-day period starts the first working day following the date of receipt of a completed application and all necessary information and verification.

**86.3(9)** *Applicant cooperation.* An applicant must cooperate with the third-party administrator in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

**86.3(10)** *Waiting lists.* When the department has established that all of the funds appropriated for this program are obligated, all subsequent applications for HAWK-I coverage shall be denied unless Medicaid eligibility exists.

*a.* The department or the third-party administrator shall mail a notice of decision to the applicant that states:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The applicant does not meet eligibility requirements, in which case the applicant shall not be put on a waiting list.

*b.* Prior to an applicant's being denied or placed on the waiting list, it must be established that the child is not eligible for Medicaid.

*c.* Applicants shall be placed on the waiting list on the basis of the date an identifiable application form specified in rule 441—76.1(249A) is received.

(1) In the event that more than one application is received on the same day, applicants shall be placed on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list.

(2) Any subsequent ties shall be determined by the month of birth of the oldest child, January being month one and the lowest number.

*d.* If funds become available, applicants shall be selected from the waiting list based on the order in which their names appear on the list and shall be notified of their selection.

*e.* After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the applicant's name shall be deleted from the waiting list and the next applicant on the waiting list shall be contacted.

[ARC 8580B, IAB 3/10/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0552C, IAB 1/9/13, effective 4/1/13; ARC 0837C, IAB 7/24/13, effective 10/1/13]

#### **441—86.4(514I) Coordination with Medicaid.**

**86.4(1)** *HAWK-I applicant eligible for Medicaid.* At the time of initial application, if it is determined the child is eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in the Medicaid program.

**86.4(2)** *HAWK-I enrollee eligible for Medicaid.* At the time of the annual review, if the child is determined eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in Medicaid effective the first day following the expiration of the 12-month HAWK-I enrollment period.

**86.4(3)** *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in the HAWK-I program if otherwise eligible.

[ARC 0837C, IAB 7/24/13, effective 10/1/13]

#### **441—86.5(514I) Effective date of coverage.**

**86.5(1)** *Initial application.* Coverage for a child who is determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4)“a,” coverage shall be effective the first day of the month following the month in which health insurance coverage is lost. Also, a one-month waiting period shall be imposed for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)“c” when the child's health insurance coverage ended in the month of application. EXCEPTIONS: A waiting period shall not be imposed if any of the following conditions apply:

- a.* The child is moving from Medicaid to HAWK-I.
- b.* The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
- c.* The cost of health insurance coverage for the child exceeds 5 percent of the family's gross income. The cost of health insurance for the child shall be the difference between the premium for coverage with and without the child.
- d.* The health insurance was provided through an individual plan.
- e.* The child's health insurance coverage was lost due to:
  - (1) Domestic violence.
  - (2) Divorce or death of a parent.

- (3) An involuntary loss of employment that qualified the parent for dependent coverage, including but not limited to layoff, business closure, reduction in hours, or termination.
- (4) A job change to a new employer that does not offer the parent dependent coverage or that requires a waiting period before children can be enrolled in dependent coverage.
- (5) Utilization of the maximum lifetime coverage amount.
- (6) Expiration of coverage under COBRA.
- (7) Discontinuation of dependent coverage by the parent's employer.
- (8) A reason beyond the control of the parent, such as a serious illness of the parent, fire, flood, or natural disaster.

**86.5(2) Referrals from Medicaid.**

*a.* Cancellation of Medicaid. Coverage for children who are determined eligible for the HAWK-I program due to cancellation of Medicaid benefits shall be effective the first day of the month after Medicaid eligibility is lost in order to ensure that there is no break in coverage. However, when such a child does not meet the provisions of paragraph 86.2(4) "a," coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

*b.* EXCEPTION: If the child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology, the child may be covered under the HAWK-I program for up to 12 months following the loss of Medicaid eligibility, regardless of the presence of other health insurance coverage.

**86.5(3) Annual renewals.** Coverage for children who are determined eligible for the HAWK-I program on the basis of an annual renewal shall be effective the first day of the month following the month in which the previous enrollment period ended.

**86.5(4) Children added to an existing HAWK-I enrollment period.** Coverage for children who are determined eligible for the HAWK-I program on the basis of a request from the family to add the child to an existing enrollment period shall be effective the first day of the month following the month in which the request was made. However, if the child does not meet the provisions of paragraph 86.2(4) "a," coverage shall be effective the first day of the month following the month in which health insurance coverage is lost unless the child is subject to a one-month waiting period in accordance with paragraph 86.2(4) "b."

[ARC 8281B, IAB 11/18/09, effective 12/23/09; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.6(514I) Selection of a plan.** At the time of initial application, if there is more than one participating health or dental plan available in the child's county of residence, the applicant shall select the health or dental plan in which the applicant wishes to enroll as part of the eligibility process. The enrollee may change plans only at the time of the annual review unless the provisions of subrule 86.7(1) or paragraph 86.6(2) "a" apply. The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.

**86.6(1) Period of enrollment.** Once enrolled in a health or dental plan, the child shall remain enrolled in the selected health or dental plan for a period of 12 months.

*a. Exceptions.* A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled unless the provisions of subrule 86.7(1) apply.

(2) The child is added to an existing enrollment. When a family requests to add an eligible child, the child shall be enrolled for the months remaining in the current enrollment period.

(3) A request to change plans is accepted in accordance with paragraphs 86.6(2) "b" and "c."

*b. Request to change plan.* An enrollee may ask to change the health or dental plan:

(1) Within 90 days following the date the initial enrollment was sent to the health or dental plan regardless of the reason for the plan change or whether the original health or dental plan was selected by the applicant or was assigned in accordance with subrule 86.6(3).

(2) At any time for cause. “Cause” as defined in 42 CFR 438.56(d)(2) as amended to May 13, 2010, includes, but is not limited to:

1. The enrollee moves out of the plan’s service area.
2. Because of moral or religious objections, the plan does not cover the services the enrollee seeks.
3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the enrollee’s primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee’s health care needs.

*c. Response to request.*

(1) If the enrollee has not requested to change health or dental plans within 90 days following the date the initial enrollment was sent to the health or dental plan and it is determined that cause does not exist, the request to change plans shall be denied.

(2) All approved changes shall be made prospectively and shall be effective on the first day of the month following the month in which the request was made.

**86.6(2) Failure to select a health or dental plan.** When more than one health or dental plan is available, if the applicant fails to select a health or dental plan within ten working days of the written request to make a selection, the third-party administrator shall select the health or dental plan and notify the family of the enrollment. The third-party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating health and dental plans.

**86.6(3) Child moves from the service area.** The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

**86.6(4) Change at annual review.** If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose. The child shall remain enrolled in the current health or dental plan if the family does not notify the third-party administrator of a new health or dental plan choice by the end of the current 12-month enrollment period.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9084B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.7(514I) Cancellation.** The child’s eligibility for the HAWK-I program shall be canceled before the end of the 12-month enrollment period for any of the following:

**86.7(1) Child moves from the service area.** Rescinded IAB 1/13/10, effective 3/1/10.

**86.7(2) Age.** The child shall be canceled from the HAWK-I program as of the first day of the month following the month in which the child attained the age of 19.

**86.7(3) Nonpayment of premiums.** The child shall be canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3), 86.8(4) and 86.8(5).

**86.7(4) Iowa residence abandoned.** The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of 441—subrule 75.10(2).

**86.7(5) Eligible for Medicaid.** The child shall be canceled from the program as of the first day of the month following the month in which Medicaid eligibility is obtained. If there are months during which the child is covered by both the Medicaid and HAWK-I programs, the HAWK-I program shall be the primary payor and Medicaid shall be the payor of last resort.

**86.7(6) Enrolled in other health insurance coverage.** The child shall be canceled from the program as of the first day of the month following the month in which the department or the third-party

administrator is notified that the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the HAWK-I program, the other insurance plan shall be the primary payor and HAWK-I shall be the payor of last resort.

**86.7(7) Admission to a nonmedical public institution.** The child shall be canceled from the program as of the first day of the month following the month in which the child enters a nonmedical public institution unless the temporary absence provisions of paragraph 86.2(3) “d” apply.

**86.7(8) Admission to an institution for mental disease.** The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

**86.7(9) Employment with the state of Iowa.** The child shall be canceled from the HAWK-I program as of the first day of the month in which the child’s parent became eligible to participate in a health or dental plan available to state of Iowa employees.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

#### **441—86.8(514I) Premiums and copayments.**

**86.8(1) Income considered.** The income considered in determining the premium amount shall be the family’s countable income using the modified adjusted gross income methodology.

**86.8(2) Premium amount.** Except as specified for supplemental dental-only coverage in subrule 86.20(3), premiums under the HAWK-I program shall be assessed as follows:

- a. No premium is charged if:
  - (1) The eligible child is an American Indian or Alaskan Native; or
  - (2) The family’s countable income is less than 181 percent of the federal poverty level for a family of the same size.
- b. If the family’s countable income is equal to or exceeds 181 percent of the federal poverty level for a family of the same size but does not exceed 242 percent of the federal poverty level for a family of that size, the premium is \$10 per child per month with a \$20 monthly maximum per family.
- c. If the family’s countable income is equal to or exceeds 243 percent of the federal poverty level for a family of the same size, the premium is \$20 per child per month with a \$40 monthly maximum per family.

**86.8(3) Due date.**

a. *Payment upon initial application.* “Initial application” means the first program application or a subsequent application that is not a renewal. Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the fifth day of the second month following the month of decision.

b. *Payment upon renewal.* “Renewal” means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the fifth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the third-party administrator shall notify the health and dental plans of the enrollment.

c. *Subsequent payments.* All subsequent premiums are due by the fifth day of each month for the next month’s coverage and must be postmarked no later than the last day of the month before the month of coverage. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. *Holiday or weekend.* When the premium due date falls on a holiday or weekend, the premium shall be due on the first business day following the due date.

**86.8(4) Grace period.** A grace period shall be allowed on any monthly premium not received as prescribed in paragraph 86.8(3) “c.” The grace period shall be the coverage month for which the premium is due.

*a.* Failure to submit a premium by the last calendar day of the grace period shall result in disenrollment.

*b.* If the premium is subsequently received, coverage will be reinstated if the premium was postmarked or otherwise paid:

- (1) In the grace period, or
- (2) In the 14 calendar days following the grace period.

**86.8(5) *Method of premium payment.*** Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the third-party administrator.

**86.8(6) *Failure to pay premium.*** Failure to pay the premium in accordance with subrules 86.8(3) and 86.8(5) shall result in cancellation from the program unless the grace period provisions of subrule 86.8(4) apply. Once a child is canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

**86.8(7) *Copayment.*** There shall be a \$25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition.

EXCEPTION: A copayment shall not be imposed when family income is less than 150 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaskan Native.

**86.8(8) *Program lock-out.*** A child who has been disenrolled from the program due to nonpayment of premiums shall be locked out of the program until the arrearage is paid in full or for a period not to exceed 90 days, whichever occurs first.

*a.* Failure to pay the unpaid premiums shall result in denial of the application if less than 90 days has elapsed since the effective date of disenrollment. EXCEPTION: The unpaid premium obligation shall be reduced to zero if upon reapplication a premium would not be assessed because the household's income is less than 150 percent of the federal poverty level.

*b.* If the arrearage is not paid within 24 months of failing to pay a premium, the debt shall be expunged and shall no longer be owed.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14]

**441—86.9(514I) Annual reviews of eligibility.** All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program. "Month one" shall be the first month in which coverage is provided.

**86.9(1) *Review form.*** A prepopulated review form on which the answers, except for income, have been completed based on the information on file shall be sent to the family. The family shall review the completed information for accuracy and fill in the income section of the form. If family income cannot be verified through electronic data matches, the family shall be required to provide verification of current income. The family shall sign and date the form attesting to its accuracy as part of the review process.

**86.9(2) *Failure to provide information.*** The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process. If the completed review form and any information necessary to establish continued eligibility are received within 14 calendar days of the end of an enrollment period, the review form and information shall be acted upon as though they had been received timely. If the fourteenth calendar day falls on a weekend or state holiday, the enrollee shall have until the next business day to provide the review form and any information necessary to establish continued eligibility.

**86.9(3) *Change in plan.*** Rescinded IAB 1/13/10, effective 3/1/10.  
[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8580B, IAB 3/10/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.10(514I) Reporting changes.** Changes that may affect eligibility shall be reported timely to the department or the third-party administrator. "Timely" shall mean no later than ten working days after the change occurred. The ten working-day period begins the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change unless the child is emancipated, married, or otherwise in an independent living situation, in which case the child shall be responsible for reporting the change.

**86.10(1)** *Entry to a nonmedical public institution.* The entry of a child into a nonmedical public institution, such as a penal institution, shall be reported following entry to the institution.

**86.10(2)** *Iowa residence is abandoned.* The abandonment of Iowa residence shall be reported following the move from the state.

**86.10(3)** *Other insurance coverage.* Enrollment of the child in other health insurance coverage shall be reported.

**86.10(4)** *Employment with the state of Iowa.* The employment of the child's parent with the state of Iowa shall be reported.

**86.10(5)** *Decrease in income.* If the family reports a decrease in income, the third-party administrator shall ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

**86.10(6)** *Information reported by a third party.* Information reported by a third party shall not be acted upon until the information is verified in accordance with subrule 86.3(7).

**86.10(7)** *Cooperation.* The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

**86.10(8)** *Effective date of change in eligibility.*

*a.* When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

*b.* When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

*c.* When an anticipated change in circumstances is reported before the change occurs, no action shall be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

[ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.11(514I) Notice requirements.** The applicant shall be provided an adequate written notice of the decision regarding the applicant's eligibility for the HAWK-I program. The enrollee shall be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice shall be timely and adequate as provided in 441—subrule 7.7(1).

[ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.12(514I) Appeals and fair hearings.** If the applicant or enrollee disputes a decision to reduce, cancel or deny participation in the HAWK-I program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 7.

[ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.13(514I) Third-party administrator.** The third-party administrator shall have the following responsibilities:

**86.13(1)** *Determination of eligibility.* Eligibility for the HAWK-I program shall be determined utilizing the department's eligibility system and in accordance with the provisions of rule 441—86.2(514I).

**86.13(2)** *Dissemination of application forms and information.* The third-party administrator shall disseminate the following:

*a.* Rescinded IAB 10/17/01, effective 12/1/01.

b. Outreach materials, application forms, or other materials developed and produced by the department to any organization or individual making a request for the materials. If the request is for quantities exceeding ten, the third-party administrator shall forward the request to Iowa prison industries for dissemination.

c. Participating health and dental plan information.

d. Other materials as specified by the department.

**86.13(3) Toll-free dedicated customer services line.** The third-party administrator shall maintain a toll-free multilingual dedicated customer service line in accordance with the requirements of the department.

**86.13(4) HAWK-I program web site.** The third-party administrator shall work in cooperation with the department to maintain a web site providing information about the HAWK-I program.

**86.13(5) Application process.** Applications shall be processed in accordance with the provisions of rule 441—86.3(514I).

a. Processing applications and mailing of approvals and denials shall be completed within ten working days of receipt of the application and all necessary information and verification unless the application cannot be processed within this period for a reason beyond the control of the third-party administrator.

b. Original verification information shall be returned to the applicant or enrollee upon completion of review.

c. Applications shall be screened for completeness. Additional information or verification necessary to establish eligibility may be requested in writing. All information or verification of information attained shall be logged.

d. Health and dental plans shall be notified when the number of enrollees who speak the same non-English language equals or exceeds 10 percent of the number of enrollees in the health or dental plan.

**86.13(6) Effective date of coverage.** The effective date of coverage shall be established in accordance with the provisions of rule 441—86.5(514I).

**86.13(7) Selection of health or dental plan.** The third-party administrator shall provide participating health and dental plan information to families of eligible children by telephone or mail and, if necessary, offer unbiased assistance in the selection of a health or dental plan in accordance with the provisions of rule 441—86.6(514I).

**86.13(8) Enrollment.** The third-party administrator shall notify participating health and dental plans of enrollments.

**86.13(9) Disenrollments.** The third-party administrator shall disenroll an enrollee when the enrollee's eligibility for the HAWK-I program is canceled in accordance with the provisions of rule 441—86.7(514I). The third-party administrator shall notify the participating health and dental plans when an enrollee is disenrolled.

**86.13(10) Annual reviews of eligibility.** Eligibility shall be reviewed annually in accordance with the provisions of rules 441—86.2(514I) and 441—86.9(514I).

**86.13(11) Acting on reported changes.** The third-party administrator shall ensure that all changes reported by the HAWK-I enrollee in accordance with rule 441—86.10(514I) are acted upon no later than ten working days from the date the change is reported.

**86.13(12) Premiums.** The third-party administrator shall:

a. Calculate premiums in accordance with the provisions of rule 441—86.8(514I).

b. Collect HAWK-I premium payments. The funds shall be deposited into an interest-bearing account maintained by the department for periodic transmission of the funds and any accrued interest to the HAWK-I trust fund in accordance with state accounting procedures.

c. Track the status of the enrollee premium payments and provide the data to the department.

d. Mail a reminder notice to the family if the premium is not received by the due date.

**86.13(13) Notices to families.** Timely and adequate approval, denial, and cancellation notices that clearly explain the action being taken in regard to an application or an existing enrollment shall be issued

to the family. Denial and cancellation notices shall clearly explain the appeal rights of the applicant or enrollee. All notices shall be available in English and Spanish.

**86.13(14) Records.** The third-party administrator shall at a minimum maintain the following records:

- a. All records required by the department and the department of inspections and appeals.
- b. Records which identify transactions with or on behalf of each enrollee by social security number or other unique identifier.
- c. Application, case and financial records.
- d. All other records as required 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.

**86.13(15) Confidentiality.** The third-party administrator shall protect and maintain the confidentiality of HAWK-I applicants and enrollees in accordance with 441—Chapter 9.

**86.13(16) Reports to the department.** The third-party administrator shall submit reports as required by the department.

**86.13(17) Systems.** The third-party administrator shall maintain data files that are compatible with the department's and the health plans' data files and shall make the system accessible to department staff. [ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.14(514I) Covered services.** The benefits provided under the HAWK-I program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act.

**86.14(1) Required medical services.** The participating health plan shall cover at a minimum the following medically necessary services:

- a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).
- b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).
- c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).
- d. Ambulance services.
- e. Physical therapy.
- f. Nursing care services (including skilled nursing facility services).
- g. Speech therapy.
- h. Durable medical equipment.
- i. Home health care.
- j. Hospice services.
- k. Prescription drugs.
- l. Rescinded IAB 1/13/10, effective 3/1/10.
- m. Hearing services.
- n. Vision services (including corrective lenses).

**86.14(2) Abortion.** Payment for abortion shall only be made under the following circumstances:

- a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.
- b. The pregnancy was the result of an act of rape or incest.

**86.14(3) Required dental services.** Participating dental plans shall cover at a minimum the following necessary dental services:

- a. Diagnostic and preventive services.
- b. Routine and restorative services.
- c. Endodontic services.

- d. Periodontal services.
  - e. Cast restorations.
  - f. Prosthetics.
- [ARC 8478B, IAB 1/13/10, effective 3/1/10]

**441—86.15(514I) Participating health and dental plans.**

**86.15(1) *Licensure.*** The participating health or dental plan must:

- a. Be licensed by the division of insurance of the department of commerce to provide health or dental care coverage in Iowa; or
- b. Be an organized delivery system licensed by the director of public health to provide health or dental care coverage.

**86.15(2) *Services.*** The participating health or dental plan shall provide coverage for the services specified in rule 441—86.14(514I) to all children determined eligible.

a. The participating health or dental plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.

b. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county in which it is licensed and in which a provider network has been established.

**86.15(3) *Premium tax.*** Premiums paid to participating health and dental plans by the third-party administrator are exempt from premium tax.

**86.15(4) *Provider network.*** The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

**86.15(5) *Identification cards.*** Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

**86.15(6) *Marketing.***

a. Participating health and dental plans may not distribute directly or through an agent or independent contractor any marketing materials.

b. All marketing materials require prior approval from the department.

c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the HAWK-I enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the health or dental plan and shall be made available to the third-party administrator for distribution.

d. All health and dental plan literature and brochures shall be approved by the department.

e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

**86.15(7) *Appeal process.*** The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

- a. Is approved by the department prior to use.
- b. Acknowledges receipt of the appeal to the enrollee.
- c. Establishes time frames which ensure that appeals be resolved within 45 days, except for appeals which involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.
- d. Ensures the participation of persons with authority to take corrective action.
- e. Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.
- f. Ensures the confidentiality of the enrollee.
- g. Ensures issuance of a written decision to the enrollee for each appeal which shall contain an adequate explanation of the action taken and the reason for the decision.
- h. Maintains a log of the appeals which is made available to the department at its request.
- i. Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.
- j. Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

**86.15(8)** *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

**86.15(9)** *Records and reports.* The participating health and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

- (1) Identifies each medical or dental record by HAWK-I enrollee identification number.
- (2) Maintains a complete medical or dental record for each enrollee.
- (3) Provides a specific medical or dental record on demand.
- (4) Meets state and federal reporting requirements applicable to the HAWK-I program.
- (5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services which are infrequently used, which provide a support system service to the operation of the health or dental plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.15(2) "b."

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

*b.* Each health or dental plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

- (1) A list of providers of services under the plan.
- (2) Encounter data on a monthly basis as required by the department.
- (3) Other information as directed by the department.

*c.* Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

- (1) Information regarding the plan's appeal process.
- (2) A plan for a health improvement program.
- (3) Periodic financial, utilization and statistical reports as required by the department.
- (4) Time-specific reports which define activity for child health care, appeals and other designated activities which may, at the department's discretion, vary among plans, depending on the services covered or other differences.

(5) Other information as directed by the department.

**86.15(10) *Systems.*** The participating health or dental plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

**86.15(11) *Payment to the participating health or dental plan.***

*a.* In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

*b.* The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

*c.* The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

*d.* If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan 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.

**86.15(12) *Quality assurance.*** The health or dental plan shall have in effect an internal quality assurance system.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

**441—86.16(514I) *Clinical advisory committee.*** Members of the clinical advisory committee established in accordance with the provisions of 441—paragraph 1.10(2)“*c*” shall be appointed to three-year terms. Members may be appointed for more than one term. No more than one-third of the membership of the committee shall rotate off the committee in any given calendar year.

**441—86.17(514I) *Use of donations to the HAWK-I program.*** If an individual or other entity makes a monetary donation to the HAWK-I program, the department shall deposit the donation into the HAWK-I trust fund. The department shall track all donations separately and shall not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to the HAWK-I board.

**86.17(1)** If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

**86.17(2)** If the donation is less than \$5,000 and the donor does not specifically identify how it is to be used, the department shall use the moneys in the following order:

- a. For the direct benefit of enrollees (e.g., premium payments).
- b. For outreach activities.
- c. For other purposes as determined by the HAWK-I board.

**86.17(3)** If the donation is more than \$5,000 and the donor does not specify how the funds are to be used, the HAWK-I board shall determine how the funds are to be used.

**441—86.18(505) Health insurance data match program.** All carriers, as defined in Iowa Code section 514C.13, shall enter into an agreement with the department to provide data necessary to allow the department to comply with the mandate of Iowa Code section 505.25. Each carrier shall either:

1. Enter into and maintain an agreement with the department on Form 470-4435, HAWK-I Data Use Agreement; or
2. Provide proof of an existing agreement with the department or the department's designee.

**441—86.19(514I) Recovery.**

**86.19(1) Definitions.**

*“Administrative error”* means an action of the department or the HAWK-I third-party administrator that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the department or the HAWK-I third-party administrator.
6. Failure to request essential verification necessary to make an accurate eligibility determination.
7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.
8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.

*“Client error”* means any action or inaction of the enrollee or the enrollee's representative that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because at least one of the following occurred:

1. The enrollee or the enrollee's representative failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. The enrollee or the enrollee's representative failed to timely report a change as defined in rule 441—86.10(514I).

**86.19(2) Amount subject to recovery from the enrollee or representative.** The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

- a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.
- b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

**86.19(3) Notification.** The enrollee shall be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

- a. The name of the person for whom funds were incorrectly paid;
- b. The period during which the funds were incorrectly paid;
- c. The amount subject to recovery; and
- d. The reason for the incorrect payment.

**86.19(4) Recovery.**

- a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

*b.* The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

*c.* Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

**86.19(5) Appeals.** The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 7.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8839B, IAB 6/16/10, effective 8/1/10; ARC 0552C, IAB 1/9/13, effective 4/1/13; ARC 0837C, IAB 7/24/13, effective 10/1/13]

#### **441—86.20(514I) Supplemental dental-only coverage.**

##### **86.20(1) Definition.**

“*Supplemental dental-only coverage*” means dental care coverage provided to a child who meets the eligibility requirements for the HAWK-I program except that the child is covered by health insurance through an individual or group health plan.

**86.20(2) Eligibility.** Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.1(514I) through 441—86.12(514I), 441—86.18(514I), and 441—86.19(514I).

**86.20(3) Premiums.** Premiums for participation in the supplemental dental-only plan are assessed as follows:

*a.* No premium is charged to families who meet the provisions of subparagraph 86.8(2) “*a*”(1) or to families whose countable income is less than 152 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology.

*b.* If the family's countable income is equal to or exceeds 152 percent of the federal poverty level but does not exceed 203 percent of the federal poverty level for a family of the same size, the premium is \$5 per child per month with a \$10 monthly maximum per family.

*c.* If the family's countable income exceeds 203 percent of the federal poverty level but does not exceed 254 percent of the federal poverty level for a family of the same size, the premium is \$10 per child per month with a \$15 monthly maximum per family.

*d.* If the family's countable income exceeds 254 percent of the federal poverty level for a family of the same size, the premium is \$15 per child per month with a \$20 monthly maximum per family.

*e.* If the family includes uninsured children who are eligible for both medical and dental coverage under HAWK-I and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:

(1) The total premium shall be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under HAWK-I because they are covered by health insurance.

*f.* The provisions of subrules 86.8(3) to 86.8(6) and 86.8(8) apply to premiums specified in this subrule.

**86.20(4) *Waiting lists.*** Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14]

These rules are intended to implement Iowa Code chapter 514I as amended by 2009 Iowa Acts, Senate File 389.

- [Filed emergency 12/23/98 after Notice 11/4/98—published 1/13/99, effective 1/1/99]
- [Filed emergency 12/23/98—published 1/13/99, effective 1/1/99]
- [Filed 2/17/99, Notice 1/13/99—published 3/10/99, effective 5/1/99]
- [Filed emergency 3/22/99—published 4/7/99, effective 4/1/99]
- [Filed 5/21/99, Notice 4/7/99—published 6/16/99, effective 8/1/99]
- [Filed 9/21/99, Notice 8/11/99—published 10/20/99, effective 12/1/99]
- [Filed emergency 1/31/00 after Notice 12/15/99—published 2/23/00, effective 2/1/00]
- [Filed emergency 5/23/00—published 6/14/00, effective 7/1/00]
- [Filed 8/30/00, Notice 6/14/00—published 9/20/00, effective 11/1/00]
- [Filed 12/20/00, Notice 10/18/00—published 1/10/01, effective 3/1/01]
- [Filed 9/19/01, Notice 8/8/01—published 10/17/01, effective 12/1/01]
- [Filed 10/23/02, Notice 9/4/02—published 11/13/02, effective 1/1/03]
- [Filed emergency 6/20/03—published 7/9/03, effective 7/1/03]
- [Filed 10/23/03, Notice 7/9/03—published 11/12/03, effective 1/1/04]
- [Filed emergency 12/16/03 after Notice 10/29/03—published 1/7/04, effective 1/1/04]
- [Filed 7/1/04, Notice 5/12/04—published 7/21/04, effective 9/1/04]
- [Filed emergency 10/19/04 after Notice 7/21/04—published 11/10/04, effective 11/1/04]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed 12/22/05, Notice 9/14/05—published 1/18/06, effective 3/1/06]
- [Filed 2/22/07, Notice 1/17/07—published 3/14/07, effective 4/18/07]
- [Filed 2/20/08, Notice 11/21/07—published 3/12/08, effective 4/16/08]
- [Filed emergency 4/8/08—published 5/7/08, effective 4/8/08]
- [Filed 6/19/08, Notice 5/7/08—published 7/16/08, effective 9/1/08]
- [Filed 10/21/08, Notice 7/30/08—published 11/19/08, effective 1/1/09]
- [Filed ARC 7770B (Notice ARC 7635B, IAB 3/11/09), IAB 5/20/09, effective 7/1/09]
- [Filed Emergency ARC 7881B, IAB 7/1/09, effective 7/1/09]
- [Filed Emergency ARC 8127B, IAB 9/9/09, effective 9/1/09]
- [Filed ARC 8109B (Notice ARC 7882B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]
- [Filed ARC 8281B (Notice ARC 8128B, IAB 9/9/09), IAB 11/18/09, effective 12/23/09]
- [Filed ARC 8280B (Notice ARC 8110B, IAB 9/9/09), IAB 11/18/09, effective 1/1/10]
- [Filed ARC 8478B (Notice ARC 8112B, IAB 9/9/09), IAB 1/13/10, effective 3/1/10]
- [Filed Emergency After Notice ARC 8580B (Notice ARC 8279B, IAB 11/18/09), IAB 3/10/10, effective 3/1/10]
- [Filed Emergency After Notice ARC 8838B (Notice ARC 8479B, IAB 1/13/10), IAB 6/16/10, effective 6/1/10]
- [Filed ARC 8839B (Notice ARC 8581B, IAB 3/10/10), IAB 6/16/10, effective 8/1/10]
- [Filed Emergency After Notice ARC 9083B (Notice ARC 8840B, IAB 6/16/10), IAB 9/22/10, effective 9/1/10]
- [Filed Emergency After Notice ARC 9084B (Notice ARC 8841B, IAB 6/16/10), IAB 9/22/10, effective 9/1/10]
- [Filed ARC 0552C (Notice ARC 0332C, IAB 9/19/12), IAB 1/9/13, effective 4/1/13]
- [Filed ARC 0837C (Notice ARC 0747C, IAB 5/15/13), IAB 7/24/13, effective 10/1/13]
- [Filed Emergency After Notice ARC 1287C (Notice ARC 1183C, IAB 11/13/13), IAB 1/8/14, effective 1/1/14]



CHAPTER 97  
COLLECTION SERVICES CENTER

PREAMBLE

The collection services center is the public agency designated by state law as the state disbursement unit with responsibility for the receipt, recording and disbursement of specified support payments within the state of Iowa. The administrative guidelines within this chapter describe the process of transferring support cases or information from the clerks of district court to the collection services center and the policies and procedures used to receive, monitor, and distribute support payments.

**441—97.1(252B) Definitions.** The definitions of terms used in this chapter shall follow those terms defined in rule 441—95.1(252B) with the exception or addition of the following:

*“Collection services center”* means the public agency designated to receive, record, monitor, and disburse support payments as defined in Iowa Code section 598.1, 252B.15 or 252D.16, in accordance with Iowa Code sections 252B.13A and 252B.14.

*“Correlated non-IV-D case”* means a non-IV-D case where income withholding information must be maintained by the unit in order to properly process an income withholding payment because the obligor has both a non-IV-D and a current or former IV-D case.

*“Electronic funds transmission”* means, for purposes of this chapter, the use of a NACHA-approved child support format for the electronic transmission of funds to the collection services center.

*“Employee”* shall have the same meaning provided this term in Iowa Code section 252G.1.

*“Former IV-D case”* means a case that previously received services from the unit under rule 441—95.2(252B) but currently receives only payment processing services from the collection services center.

*“Insufficient funds payment”* means a support payment by check or other financial instrument which is dishonored, not paid, or the funding of the payment is determined to be inadequate.

*“IV-D case”* means a case that receives services from the unit under rule 441—95.2(252B), including payment processing services from the collection services center.

*“NACHA-approved child support format”* means a child support payment transmission format approved by the National Automated Clearing House Association (NACHA).

*“Non-IV-D case”* means a support order that never received services from the unit under rule 441—95.2(252B), but that receives payment processing services from the collection services center for income withholding payments.

*“Obligee”* means the guardian, custodial parent, person, or entity entitled to receive support payments.

*“Obligor”* means a parent, relative, or any other person declared to be legally liable for the support of a child or the custodial parent or guardian of the child.

*“Payor of income”* shall have the same meaning provided this term in Iowa Code section 252D.16.

*“Support payment”* shall have the same meaning provided this term in Iowa Code section 252D.16.

*“Unit”* means the child support recovery unit as defined in Iowa Code section 252B.2.

*“Web site”* means the Web site operated by the department of human services for the purpose of allowing a payor of income to make a support payment through electronic transmission to the collection services center.

[ARC 9351B, IAB 2/9/11, effective 4/1/11]

**441—97.2(252B) Transfer of records and payments.** For non-IV-D cases, the clerk of court shall provide core case information to the unit upon the filing of a new income withholding order or upon the request of the unit. “Core case information” means information listed in paragraphs 97.2(1) “a” and “b” and subrule 97.2(2). For IV-D and correlated non-IV-D cases, the clerk of court shall provide detailed case information to the unit upon request. After the establishment of a case, the unit shall send notices of transfer to obligors, obligees, and payors of income based upon case type.

**97.2(1)** *Transfer of information on non-IV-D and correlated non-IV-D cases.*

a. In non-IV-D cases, the unit shall request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:

- (1) The obligor's name and address.
- (2) The obligee's name and address.
- (3) The court order numbers.

b. In correlated non-IV-D cases, the unit shall request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:

- (1) The obligor's name and address.
- (2) The obligee's name and address.
- (3) The court order numbers.
- (4) The income withholding order.

c. The clerk of the district court shall provide case information to the unit on a regular basis when an income withholding order is filed with a clerk of court or when the unit requests the information in order to process a payment.

d. The unit shall automatically create cases for payment processing based upon the information received from the clerks of court.

**97.2(2)** *Transfer of information on IV-D cases.* In IV-D cases, the clerk of district court shall provide the unit with the following information if the information has been provided to the clerk upon request of the unit:

a. The obligee's name, date of birth, last-known mailing address, the social security number if known and, if different in whole or part, the names of the persons to whom the obligation of support is owed by the obligor.

b. The name, birth date, social security number, and last-known mailing address of the obligor.

c. A copy of all support orders that establish or modify a support amount.

d. The names, social security numbers, and dates of birth of any minor dependents for whom support is ordered, if available.

e. A record of any support payments received by the clerk of district court prior to the transfer of case information and any payments received by the collection services center and the date of transfer to the collection services center.

f. A record of any determination of controlling order under the Uniform Interstate Family Support Act.

**441—97.3(252B) Support payment records.** Each IV-D, former IV-D and non-IV-D case type shall have an official payment record.

**97.3(1)** *Official records for cases.* The official payment records for each case type shall be maintained by a designated entity.

a. The collection services center shall establish, maintain and certify the official support payment records for IV-D or former IV-D cases.

b. The clerk of the district court shall establish, maintain and certify the official support payment records for non-IV-D and correlated non-IV-D cases. The collection services center shall establish and maintain records for receipt and disbursement of income withholding payments for these cases, but shall not certify these records as the complete payment record.

**97.3(2)** *Informal conference for payment records.* The unit shall provide an informal conference or desk review regarding the contents of any support payment record to the obligor or obligee upon request.

a. In IV-D or former IV-D cases, the conference shall be available to review the payment record and to answer questions of the obligee or obligor regarding the accuracy of the record.

b. In non-IV-D and correlated non-IV-D cases, the conference shall be available to review the accuracy of the contents of any record of income withholding payments.

**97.3(3)** *Certified payment records.* The unit shall provide certified copies of the official support payment records as defined in paragraph 97.3(1)“a” in accordance with Iowa Code section 252B.9.

[ARC 1262C, IAB 1/8/14, effective 3/1/14]

**441—97.4(252B) Method of payment.** Payments shall be accepted in specific forms from obligors and payors of income.

**97.4(1) Form of payment.** Except as otherwise provided in this rule and in rule 441—97.5(252D), support payments may be paid in the form of cash, check, bank draft, money order, preauthorized withdrawal of funds, or other financial instrument, and sent by mail to the collection services center, or by electronic transmission of funds.

**97.4(2) Treatment of insufficient funds payments.** The unit shall have a process in place to handle insufficient funds payments.

*a.* An obligor submitting an insufficient funds support payment to the collection services center shall be required to submit payments by cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

*b.* A payor of income submitting an insufficient funds support payment to the collection services center shall be required to submit payments through electronic funds transmission, cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

*c.* Insufficient funds payments shall not be credited to the collection services center account for the obligor or shall be removed from the account if credited before sufficiency was verified. Insufficient funds support payments shall be subject to additional collection by the collection services center for the dishonored amount.

*d.* The collection services center shall not process additional payments other than cash, bank drafts or money orders from an obligor or payor of income who has previously submitted insufficient funds payments without first verifying the payment. The collection services center shall have a process in place to allow the obligor or the payor of income the opportunity to replace any additional moneys submitted for payment of support before processing in order to avoid additional insufficient funds entries into the official payment records on the affected cases.

**97.4(3) Distribution of payment.** Nonincome withholding support payments received by the collection services center in IV-D, former IV-D, non-IV-D, or correlated non-IV-D cases which are not directed to a specific account or support obligation shall first be applied proportionately to the current support obligation on all cases for the obligor and, secondly, to the support arrearages owed by the obligor.

[ARC 9351B, IAB 2/9/11, effective 4/1/11]

**441—97.5(252D) Electronic transmission of payments.** Payors of income shall electronically transmit to the collection services center the amounts withheld under an income withholding order.

**97.5(1) Thresholds for electronic funds transmission.** A payor of income shall transmit payment through electronic funds transmission if either of the following applies:

- a.* The payor of income employs 100 or more employees and uses an agent for payroll processing.
- b.* The payor of income employs 200 or more employees.

**97.5(2) Use of the Web site.** Unless paragraph 97.4(2) “*b*” applies, a payor of income required to use electronic funds transmission under subrule 97.5(1) may elect to submit payments electronically by using the Web site if the payor of income determines that using electronic funds transmission would cause undue hardship.

**97.5(3) Implementing electronic funds transmission.** A payor of income implementing electronic funds transmission shall complete all the following before the implementation date specified in subrule 97.5(5):

- a.* Contact the collection services center to obtain file layout and case reconciliation information.
- b.* Provide to the collection services center:
  - (1) The contact information for the person responsible for electronic funds transmission for the payor of income or the payor of income’s agent for payroll processing;
  - (2) The contact information for the person responsible for payroll accounts for the payor of income or the payor of income’s agent for payroll processing;
  - (3) The name and address of the authorized financial institution from which the payment will be withheld; and

(4) A sample file layout in a NACHA-approved child support format and, if necessary, a test file in a NACHA-approved child support format.

c. If needed upon review by the collection services center:

(1) Make corrections to the file layout to meet a NACHA-approved child support format, and

(2) Provide a corrected copy to the collection services center for review.

d. Upon approval of the file layout by the collection services center, provide an implementation date before the first submission of payment through electronic funds transmission.

**97.5(4) *Maintaining information and file format after implementation.*** A payor of income that has implemented electronic funds transmission shall:

a. Transmit both payment amounts and detailed information records in accordance with a NACHA-approved child support format.

b. Advise the collection services center of a payment error within two business days.

c. Provide the collection services center ten working days' advance notice when changing between NACHA-approved child support formats.

d. Correct case number or file problems identified by the collection services center before sending any additional files.

**97.5(5) *Time frames for implementation.*** A payor of income shall comply with the following implementation schedule:

a. A payor of income that employs 1,000 or more employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2011.

b. A payor of income that employs between 500 and 999 employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2012.

c. A payor of income that employs between 200 and 499 employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2013.

d. A payor of income that employs 100 or more employees and uses an agent for payroll processing shall implement electronic funds transmission or begin using the Web site no later than December 31, 2013.

**97.5(6) *Exemption from electronic transmission.*** To avoid undue hardship, a payor of income that has fewer than 200 employees or a payor of income that has fewer than 100 employees and uses an agent for payroll processing is exempt from using electronic transmission unless subrule 97.4(2) applies.

[ARC 9351B, IAB 2/9/11, effective 4/1/11]

**441—97.6(252B) Authorization of payment.** The collection services center must authorize the generation of payments for support paid. The collection services center shall issue payments as follows:

**97.6(1) *Submittal of information to department of administrative services.*** In order to disburse payments to the obligee within two working days, the collection services center shall submit information daily to the department of administrative services to issue a warrant or electronic file transfer (EFT) payment to the obligee.

**97.6(2) *Release of funds.*** The following workday an electronic transfer of funds shall be sent to the designated account of the obligee or an alternate account to be accessed by the obligee through an electronic access card, or if subrule 97.6(5) applies, a state warrant may be sent by regular mail to the last-known address of the obligee.

**97.6(3) *Electronic transfer.*** Obligees who want electronic transfer of support payments to a designated account shall complete Form 470-2612, Authorization for Automatic Deposit, and submit it to the collection services center. Unless subrule 97.6(5) applies, any obligee not using automatic deposit to a designated account shall be issued an electronic access card for receipt of support payments.

**97.6(4) *Walk-ins.*** Support payments shall not be hand-delivered to the obligee on a walk-in basis.

**97.6(5) *Warrants.*** The collection services center may authorize generation of a warrant if any one of the following conditions applies:

a. Generation of a warrant is necessary to meet federal requirements to disburse a payment to an obligee within two working days when electronic transfer is not feasible.

*b.* The obligee has not requested automatic deposit to a designated account of the obligee, and payment is from a source that is nonrecurring or is not expected to continue in a 12-month period.

*c.* The obligee has not requested automatic deposit to a designated account of the obligee and has asserted in writing on Form 470-3972, Electronic Support Payments, that one of the exemptions listed in this paragraph applies. To claim an exemption, the obligee must return Form 470-3972 to the collection services center within ten days of the date the form was issued. An exemption granted under this paragraph is subject to periodic review by the collection services center. When the collection services center reviews an exemption, it shall issue Form 470-3973, Review of Electronic Transfer Exemption, to the obligee for completion. The exemptions available under this paragraph are:

- (1) A physical disability imposes a hardship in accessing an electronically transferred payment.
- (2) A mental disability imposes a hardship in accessing an electronically transferred payment.
- (3) A language barrier imposes a hardship in accessing an electronically transferred payment.
- (4) A literacy barrier imposes a hardship in accessing an electronically transferred payment.
- (5) The obligee's home and work addresses are more than 30 miles from an automated teller machine and more than 30 miles from a financial institution where the account funds can be accessed.

*d.* The representative payee, court appointee, or trustee notifies the collection services center or unit in writing that one of the following applies:

- (1) The obligee is under a court-ordered guardianship or conservatorship.
- (2) The obligee is involved in other legal proceedings, including bankruptcy, which require payments to be sent to a trustee or other representative payee.

**441—97.7(252B) Processing misdirected payments.** If the collection services center receives a payment for which a corresponding obligee cannot be identified, the collection services center shall contact the person or entity that directed the payment to obtain additional information. Payments inappropriately directed to the collection services center shall be returned to the person or entity sending the payment.

These rules are intended to implement Iowa Code sections 252B.13A through 252B.17 and section 252D.17.

[Filed emergency 3/26/87 after Notice 2/11/87—published 4/22/87, effective 4/1/87]

[Filed 7/14/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]

[Filed without Notice 8/15/02—published 9/4/02, effective 11/1/02]

[Filed emergency 2/13/03 after Notice 9/4/02—published 3/5/03, effective 3/1/03]

[Filed 4/10/03, Notice 2/19/03—published 4/30/03, effective 7/1/03]

[Filed emergency 1/19/07—published 2/14/07, effective 1/20/07]

[Filed ARC 9351B (Notice ARC 9215B, IAB 11/3/10), IAB 2/9/11, effective 4/1/11]

[Filed ARC 1262C (Notice ARC 1045C, IAB 10/2/13), IAB 1/8/14, effective 3/1/14]



CHAPTER 119  
RECORD CHECK EVALUATIONS FOR  
CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

PREAMBLE

These rules establish procedures for the performance of record check evaluations by the department of human services for personnel employed by health care facilities and other programs and for students in educational training programs for nurses and certified nurse aides. Record check evaluations are performed, at the request of a prospective employer or training program, on persons who have been found to have been convicted of a crime under a law of any state or have a record of founded child or dependent adult abuse, to determine whether the crimes or founded abuses warrant prohibition of employment or enrollment in a training program.

[ARC 0486C, IAB 12/12/12, effective 2/1/13]

**441—119.1(135B,135C) Definitions.**

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

“*Requesting entity*” means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can be employed by the entity or participate in an educational training program and includes the following:

1. Health care facilities as defined in Iowa Code section 135C.1.
2. Programs in which the provider is regulated by the state or receives any state or federal funding and the employee being evaluated provides direct services to consumers including but not limited to programs that employ homemakers or home health aides, programs that provide adult day services, hospices, federal home- and community-based services waiver providers, elder group homes, and assisted living programs.
3. Substance abuse programs for juveniles as described in Iowa Code section 125.14A.
4. Hospitals as defined in Iowa Code section 135B.1.
5. Psychiatric medical institutions for children as defined in Iowa Code section 135H.1.
6. The department as described in Iowa Code section 217.44.
7. Department institutions as defined in Iowa Code section 218.13.
8. Child foster care facilities as defined in Iowa Code section 237.1.
9. Medicaid home- and community-based services waiver providers as defined in Iowa Code section 249A.29.
10. Certified nurse aide training programs as defined in Iowa Code section 135C.33(8).
11. Nursing training programs as described in Iowa Code chapter 152.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14]

**441—119.2(135B,135C) When record check evaluations are requested.**

**119.2(1)** *Record check evaluations on prospective employees and students.* A requesting entity shall request a record check evaluation prior to employment or enrollment of a person whose background check indicates a criminal or dependent adult abuse or child abuse record. Criminal, child abuse and dependent adult abuse background checks are required on all prospective employees or students, including employees or students who have terminated employment or participation in a training program for any reason or any length of time and wish to return to the same employment or training program, unless an exemption is provided in these rules.

*a.* A hospital or licensee of a health care facility may employ a person for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

- (1) The employment does not involve operation of a motor vehicle; and
- (2) The person to be employed has been convicted of a simple misdemeanor offense (under Iowa Code section 123.47 or chapter 321) or a first offense of operating a motor vehicle while intoxicated (under Iowa Code section 321J.2(1)); and

(3) The person to be employed does not have a record of founded child or dependent adult abuse; and

(4) The hospital or licensee has requested an evaluation.

*b.* A training program in a facility licensed under Iowa Code chapter 135C may allow a student who is applying for, enrolled in, or returning to a certified nurse aide training program to participate in the clinical education component of the training program for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

(1) The student's clinical education component of the training program involves children or dependent adults; and

(2) The program does not involve operation of a motor vehicle; and

(3) The student has been convicted of a simple misdemeanor offense (under Iowa Code section 123.47 or chapter 321) or a first offense of operating a motor vehicle while intoxicated (under Iowa Code section 321J.2(1)); and

(4) The student does not have a record of founded child or dependent adult abuse; and

(5) The training program has requested an evaluation.

**119.2(2)** *Record check evaluations on current employees and students.* A requesting entity shall request a record check evaluation on current employees and students when a current employee or student background check indicates a criminal conviction (other than an Iowa Code chapter 321 simple misdemeanor or equivalent simple misdemeanor offense from another jurisdiction) or dependent adult or child abuse record and the requesting entity intends to continue to employ the employee or to continue the student's enrollment in a training program. The requesting entity shall request a current criminal or dependent adult or child abuse record check when the entity receives credible information as determined by the entity that a current employee or student has a criminal or dependent adult or child abuse record that has not been previously considered by the requesting entity.

**119.2(3)** *Transfer of employee between facilities.* If a person owns or operates more than one facility, and an employee of one of the facilities is transferred to another facility without a lapse in employment, the facility is not required to request additional criminal or abuse record checks of the employee or obtain a new record check evaluation.

**119.2(4)** *Exceptions to record check evaluation requirements for employment under Iowa Code chapter 135B or 135C or participation in a training program in facilities licensed under Iowa Code chapter 135C.* If an evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment, the person who is or was employed by a hospital licensed under Iowa Code chapter 135B and is hired by another hospital or the person who is or was employed by a facility licensed under Iowa Code section 135C.33 and is hired by another facility licensed under Iowa Code section 135C.33 may commence employment without further action by the department subject to the following conditions:

*a.* The record check performed by the subsequent employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

*b.* The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

*c.* Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

*d.* The person subject to the record checks has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a new record check evaluation shall be performed.

*e.* Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

*f.* The subsequent employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

**119.2(5)** *Exceptions to record check evaluation requirements for new employees under Iowa Code chapter 135B or 135C or participants in a training program in facilities licensed under Iowa Code chapter 135C.* If the person approved for employment or participation does not start employment or attend the training program, as defined in subrule 119.4(3), within 30 days from the notice of decision approving the person, the requesting entity must perform a new record check.

*a.* If the evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment or participation in a training program, the person being considered for employment may commence employment without further action by the department subject to the following conditions:

(1) The record check performed by the employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

(2) The position with the employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

(3) Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

(4) The employer or person subject to the record checks has maintained a copy of the previous evaluation. If a physical copy of the previous evaluation is not maintained, a new record check evaluation shall be requested.

(5) Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

(6) The employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

*b.* If the record check indicates that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation, a new record check evaluation shall be performed.

*c.* Record check evaluations completed in accordance with paragraph 119.4(3) "c" are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply. "Start employment or attend the training program" means to begin to receive a salary or take classes.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14]

#### **441—119.3(135C) Request for evaluation.**

**119.3(1)** *Required documentation.* The requesting entity and the prospective employee or student shall complete and submit the record check evaluation form to the department to request an evaluation. The requesting entity shall submit the form and required documentation to the Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, Iowa 50305-4826. The department shall not process evaluations that are not signed by the prospective employee or student. The position sought or held must be clearly written on the first page of the record check evaluation form. The form shall be accompanied by the following documents:

*a.* A copy of the documentation of the person's status on the DCI criminal history database generated within 30 days of the date on which the request for evaluation is submitted to the department.

*b.* A copy of the Iowa criminal history data, if there is a history, as provided to the requesting entity by the division of criminal investigation.

*c.* A copy of the documentation of the person's status on the dependent adult abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

*d.* A copy of the documentation of the person's status on the child abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

#### **119.3(2)** *Additional documentation.*

*a.* The requesting entity may provide or the department may request from the prospective employee or student or from the requesting entity information to assist in performance of the evaluation that includes, but is not limited to, the following:

(1) Documentation of criminal justice proceedings.

- (2) Documentation of rehabilitation.
- (3) Written employment references or applications.
- (4) Documentation of substance abuse education or treatment.
- (5) Criminal history records, child abuse information, and dependent adult abuse information from other states.

(6) Documentation of the applicant's prior residences.

*b.* Any person or agency that might have pertinent information regarding the criminal or abuse history and rehabilitation of a prospective employee or student may be contacted.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14]

#### **441—119.4(135B,135C) Completion of evaluation.**

**119.4(1) Considerations.** The department shall consider the following when conducting a record check evaluation:

- a.* The nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held.
- b.* The time elapsed since the commission of the crime or founded child or dependent adult abuse.
- c.* The circumstances under which the crime or founded abuse was committed.
- d.* The degree of rehabilitation.
- e.* The likelihood that the person will commit a crime or founded child or dependent adult abuse again.
- f.* The number of crimes or instances of founded child or dependent adult abuse committed by the person involved.

**119.4(2) Evaluation conclusions.**

- a.* The department may determine the following:
  - (1) The person may be employed by the entity or enroll in the training program with no restrictions.
  - (2) The person may be employed by the entity or enroll in the training program with restrictions.
  - (3) The person may be employed by the entity or enroll in the training program with restrictions specific to a position within the program.
  - (4) The person may not be employed by the entity or enroll in the training program.
- b.* Restrictions on a person's employment or enrollment status shall be based upon what is necessary for the protection of the person or persons receiving care.
- c.* Medicaid waiver consumer-directed attendant care evaluations shall determine that either the person may work or the person may not work pursuant to Medicaid law.

**119.4(3) Notice of decision.** The department shall issue a notice of decision in writing to the requesting entity. The requesting entity is responsible for providing a copy of the notice to the prospective employee or student.

- a.* The notice shall be valid only for employment with the employer or enrollment in a training program that requested the record check evaluation.
- b.* The notice shall not be valid for employment with any other prospective employer or enrollment in another training program.
- c.* Record check evaluations are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply. "Start employment or attend the training program" means to begin to receive a salary or take classes.

*d.* The notice of decision shall contain the notice of right to appeal.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14]

**441—119.5(135B,135C) Appeal rights.** Any person or the person's attorney may file a written statement with the department requesting an appeal of the record check evaluation decision within 30 days of the date of the notice of the results of the record check evaluation in accordance with 441—Chapter 7.

[ARC 1263C, IAB 1/8/14, effective 3/1/14]

These rules are intended to implement Iowa Code section 135C.33.

[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]

[Filed ARC 0486C (Notice ARC 0324C, IAB 9/5/12), IAB 12/12/12, effective 2/1/13]

[Filed ARC 1263C (Notice ARC 1046C, IAB 10/2/13), IAB 1/8/14, effective 3/1/14]



**PROFESSIONAL LICENSURE DIVISION[645]**

Created within the Department of Public Health[641] by 1986 Iowa Acts, chapter 1245.  
Prior to 7/29/87, for Chs. 20 to 22 see Health Department[470] Chs. 152 to 154.

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CHAPTER 100  
PRACTICE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS,  
AND CREMATION ESTABLISHMENTS

[Prior to 9/21/88, see Health Department[470] Ch 146]

**645—100.1(156) Definitions.**

*“Alternative container”* means an unfinished wood box or other nonmetal receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed for the encasement of human remains and which is made of fiberboard, pressed wood, composition materials (with or without an outside covering) or like materials which prevents the leakage of body fluid.

*“Authorized person”* means that person or persons upon whom a funeral director may reasonably rely when making funeral arrangements including, but not limited to, embalming, cremation, funeral services, and the disposition of human remains pursuant to 2008 Iowa Acts, Senate File 473, section 10.

*“Autopsy”* means the postmortem examination of a human remains.

*“Board”* means the board of mortuary science.

*“Body parts”* means appendages or other portions of the anatomy that are from a human body.

*“Burial.”* See *“Interment.”*

*“Burial transit permit”* means a legal document authorizing the removal and transportation of a human remains.

*“Casket”* means a rigid container which is designed for the encasement of human remains and which is usually constructed of wood, metal, fiberglass, plastic or like material and ornamented and lined with fabric.

*“Cemetery”* means an area designated for the final disposition of human remains.

*“Change of ownership”* means a change of controlling interest in a funeral establishment or crematory establishment.

*“Columbarium”* means a structure, room or space in a mausoleum or other building containing niches or recesses for disposition of cremated remains.

*“Common carrier”* means any carrier engaged in the business of transportation of persons or property from place to place for compensation, and who offers services to the public generally.

*“Cremated remains”* means all the remains of the cremated human body recovered after the completion of the cremation process, including pulverization which leaves only bone fragments reduced to unidentifiable dimensions and may possibly include the residue of any foreign matter including casket material, bridgework or eye glasses that were cremated with the human remains.

*“Cremation”* means the technical process, using heat and flame, that reduces human remains to bone fragments. The reduction takes place through heat and evaporation. Cremation shall include the processing, and may include the pulverization, of the bone fragments.

*“Cremation authorization form”* means a form, completed and signed, to accompany all human remains accepted for cremation.

*“Cremation chamber”* means the enclosed space within which the cremation takes place.

*“Cremation establishment”* means a place of business which provides any aspect of cremation services.

*“Cremation permit”* means a permit issued by a medical examiner allowing cremation of human remains.

“*Cremation room*” means the room in which the cremation chamber is located.

“*Crematory*” means any person, partnership or corporation that performs cremation.

“*Crypt*” means a chamber in a mausoleum of sufficient size to contain casketed human remains.

“*Custody*” means immediate charge and control exercised by a person or an authority.

“*Dead body.*” See “*Human remains.*”

“*Death certificate*” means a legal document containing vital statistics pertaining to the life and death of the decedent.

“*Decedent.*” See “*Human remains.*”

“*Disinterment*” means to remove human remains from their place of final disposition.

“*Disinterment application*” means a legal document requesting authorization from the department of public health to disinter a casketed human remains or an urn containing cremated remains from its place of final disposition.

“*Disinterment application number*” means the number assigned to a disinterment application by the department of public health, giving the funeral director the authority to disinter a casketed human remains or an urn containing cremated remains from its place of final disposition.

“*Embalming*” means the disinfecting or preserving of dead human remains, entire or in part, by the use of chemical substances, fluids or gases in the body, or by the introduction of same into the body by vascular or hypodermic injections, or by surface application into or on the organs or cavities for the purpose of preservation or disinfection.

“*Embalming record*” means a record completed by the licensed funeral director or registered intern for each body embalmed in Iowa, or otherwise prepared for disposition by the licensee. “Embalming record” includes, at a minimum, a case analysis and a detailed listing of the procedures or treatments or both performed on the deceased.

“*Entombment*” means to place a casketed body or an urn containing cremated remains in a structure such as a mausoleum, crypt, tomb or columbarium.

“*Final disposition*” means the burial, interment, cremation, removal from the state, or other disposition of a dead body or fetus.

“*First call*” means the original notification to the funeral director indicating the place of death from which the human remains are to be removed.

“*Funeral ceremony*” means a service commemorating the decedent.

“*Funeral director*” means a person licensed by the board to practice mortuary science.

“*Funeral establishment*” means a place of business as defined by the board devoted to providing any aspect of mortuary science.

“*Funeral rule*” means the Federal Trade Commission rule.

“*Funeral services*” means any services which may be used to (1) care for and prepare deceased human remains for burial, cremation or other final disposition; and (2) arrange, supervise or conduct the funeral ceremony or final disposition of deceased human remains.

“*Holding facility*” means an area isolated from the general public that is designated for the temporary retention of human remains.

“*Human remains*” means a deceased human being for which a death certificate or fetal death certificate is required.

“*Interment*” means to place a casketed human remains or an urn containing cremated remains in the ground.

“*Intern*” means a person registered by the board to practice mortuary science under the direct supervision of a preceptor certified by the board pursuant to 645—subrule 101.5(2).

“*Mausoleum*” means an aboveground structure designed for entombment of human remains.

“*Medical examiner*” means a public official whose primary function is to investigate and determine cause of death when death may be thought to be from other than natural causes.

“*Memorial ceremony*” means a service commemorating the decedent.

“*Niche*” means a recess or space in a columbarium or mausoleum used for placement of cremated human remains.

“*Outer burial container*” means any container which is designed for placement in the ground around a casket or an urn including, but not limited to, containers commonly known as burial vaults, urn vaults, grave boxes, grave liners, and lawn crypts.

“*Preparation room*” means a room in a funeral establishment where human remains are prepared, sanitized, embalmed or held for ceremonies and final disposition.

“*Pulverization*” means a process following cremation which reduces identifiable bone fragments into granulated particles.

“*Removal*” means the act of taking a human remains from the place of death or place where a human remains is being held, to a funeral establishment or other designated place.

“*Scattering area*” means a designated area where cremated remains may be commingled with other cremated remains.

“*Temporary cremated remains container*” means a durable receptacle designed for short-term retention of cremated remains.

“*Their own dead*” refers to the legal authority the authorized person has regarding a human remains.

“*Topical disinfection*” means the direct application of chemical substances on the surface of a human remains for the purpose of preservation or disinfection.

“*Transfer.*” See “*Removal.*”

“*Universal precautions*” means a concept of care based upon the assumption that all blood and body fluids, and materials that have come into contact with blood or body fluids, are potentially infectious.

“*Urn*” means a receptacle designed for permanent retention of cremated remains.

[ARC 9239B, IAB 11/17/10, effective 12/22/10; ARC 1274C, IAB 1/8/14, effective 2/12/14]

#### **645—100.2(156) Funeral director duties.**

**100.2(1)** Practices requiring a funeral director’s license include but are not limited to:

- a. Removal as specified in rule 645—100.4(142,156).
- b. Embalming deceased human beings as specified in rule 645—100.6(156) and completing embalming records as specified in paragraph 100.11(2)“d.”
- c. Conducting funeral arrangements as specified in subrule 100.7(2).
- d. Conducting funeral services when contracted to do so, including:
  - (1) Direct supervision of visitation and viewing.
  - (2) Funeral and memorial ceremonies.
  - (3) Committal and final disposition services.
- e. Cremation services as specified in rule 645—100.10(156).
- f. Signing death certificates and performing associated duties under Iowa Code chapter 144.

**100.2(2)** Registered interns. Registered interns may provide funeral director services identified in subrule 100.2(1), paragraphs “a” through “f,” under the direct supervision of an Iowa-licensed preceptor. However, registered interns shall not sign death certificates.

**100.2(3)** CDC universal precautions and OSHA standards. The funeral director shall observe current guidelines of universal precautions as prescribed by the Centers for Disease Control (CDC) as well as Occupational Safety and Health Administration (OSHA) standards.

**100.2(4)** Funeral directors who provide mortuary science services from funeral establishments located in another state. A funeral director who holds an active Iowa funeral director’s license and whose practice is conducted from a funeral establishment located in another state may provide mortuary science services in Iowa if the establishment holds a current license in the state in which it is located, if such a license is required.

**100.2(5)** Withholding human remains. A funeral director shall not withhold human remains based solely on nonpayment of fees.

[ARC 9239B, IAB 11/17/10, effective 12/22/10; ARC 1274C, IAB 1/8/14, effective 2/12/14]

#### **645—100.3(156) Permanent identification tag.**

**100.3(1)** The funeral director who assumes possession of the human remains shall attach a permanent identification tag.

**100.3(2)** The identification tag shall initially contain, at a minimum, the name of the deceased.

**100.3(3)** Before final disposition, the identification tag shall contain the name of the deceased, date of birth, date of death and social security number of the deceased and the name and license number of the funeral home in charge of disposition.

**100.3(4)** The identification tag shall be attached to the remains throughout the entire time the body is in the possession of the funeral home and shall remain with the human remains.

**645—100.4(142,156) Removal and transfer of dead human remains and fetuses.**

**100.4(1)** Removal and transfer of dead human remains. The funeral director shall perform the following duties upon notification of a death.

*a.* Comply with jurisdictional authority, with respect to medico-legal responsibilities, regarding the removal of the human remains.

*b.* Provide signature and license number when removing a dead human remains from a hospital, nursing establishment or any other institution involved with the care of the public.

**100.4(2)** After the funeral director has assumed custody of the human remains, the funeral director may delegate the task of transferring the dead human remains to an unlicensed employee or agent. Prior to transfer, the funeral director shall topically disinfect the body, secure all body orifices to retain all secretions, place the human remains in a leakproof container for transfer that will control odor and prevent the leakage of body fluids, and issue a burial transit permit.

**100.4(3)** A funeral director may delegate the transportation of unembalmed human remains to an unlicensed employee or agent of the funeral home without first assuming custody and without topically disinfecting or securing body orifices if all of the following are true:

*a.* The transportation is to or from the medical examiner's office, or otherwise at the direction of the medical examiner;

*b.* The remains are placed in a leakproof container by medical examiner personnel; and

*c.* The employee or agent is issued a burial transit permit or other evidence of authorization.

**100.4(4)** An unlicensed employee or agent referred to in subrules 100.4(2) and 100.4(3) shall have completed the annual OSHA training related to blood-borne pathogens.

[ARC 9239B, IAB 11/17/10, effective 12/22/10]

**645—100.5(135,144) Burial transit permits.** A licensed funeral director may issue a burial transit permit for the removal and transfer of dead human remains and such burial transit permit shall be issued in accordance with state law and the administrative rules promulgated by the department of public health regarding burial transit permits.

**645—100.6(156) Prepreparation and embalming activities.**

**100.6(1)** The funeral director shall perform the following duties prior to and during embalming according to commonly accepted industry standards.

*a.* Permission for embalming. The funeral director shall obtain authorization for embalming from an authorized person. If permission to embalm cannot be obtained from the authorized person, the funeral director may proceed with the embalming if necessary to comply with subrule 100.6(3).

*b.* Embalming shall be done entirely in private. No one except the funeral director, intern, immediate family, or student shall be allowed in the preparation room without the written permission of the authorized person. A student must be under the direct physical supervision of the funeral director and currently enrolled and attending a program of mortuary science which is recognized by the board to be allowed in the preparation room during the embalming without written permission.

*c.* The human remains shall be properly covered at all times.

*d.* Conduct a preembalming case analysis of the human remains. Recognize the potential chemical effects on the body and select the proper embalming chemicals based upon the analysis.

*e.* Position the human remains on the preparation table and pose the facial features.

*f.* Select points of drainage and injection, and raise the necessary vessels.

g. Embalming shall include arterial and cavity injection of embalming chemicals. If the condition of the human remains does not allow arterial and cavity injection of embalming chemicals, topical embalming, using appropriate chemicals and procedures, shall be performed.

h. Once the arterial and cavity injection of the embalming chemicals is complete, evaluate the distribution of the embalming chemicals and perform treatment for discoloration, vascular difficulties, decomposition, dehydration, purge and close any incisions.

**100.6(2)** Postembalming activities. The funeral director shall perform the following duties at the conclusion of the embalming activities if necessary.

a. Pack or otherwise secure all body orifices with material which will absorb and retain all secretions.

b. Apply chemicals topically and perform hypodermic treatments.

c. Bathe, disinfect and reposition the human remains.

d. Clean and disinfect the embalming instruments, equipment and preparation room.

e. Perform any restorative treatments.

f. Select and apply the appropriate cosmetic treatments.

g. Prepare the human remains for viewing.

**100.6(3)** Care of the unembalmed human remains.

a. Embalming may be omitted provided that interment or cremation is performed within 72 hours after death or within 24 hours of taking custody if the human remains were previously in the custody of others, whichever is longer.

b. If refrigeration is utilized, embalming or final disposition may be extended up to 72 hours longer than the maximum period provided in paragraph 100.6(3) "a." The body must be kept between 38 and 42 degrees Fahrenheit.

c. If viewing of the unembalmed human remains is requested, the human remains shall be topically disinfected and all body orifices shall be packed or otherwise secured with material which will absorb and retain all secretions.

[ARC 9239B, IAB 11/17/10, effective 12/22/10]

#### **645—100.7(156) Arranging and directing funeral and memorial ceremonies.**

**100.7(1)** *The Federal Trade Commission.* The funeral director shall observe current guidelines of the Federal Trade Commission (FTC) funeral rule.

**100.7(2)** *Arrangement conference activities.* If responsible the funeral director shall perform the following duties associated with arranging ceremonies and the final disposition of a human remains.

a. Gather necessary statistical and biographical information relating to the decedent and explain the varied use of the information gathered.

b. Present, discuss and explain the mandated Federal Trade Commission price lists and assist or provide the consumer with:

(1) The types of ceremony or final disposition.

(2) The specific goods and services.

(3) The prices of any goods and services.

(4) The written, itemized statement of the funeral goods and services.

(5) A general price list.

At the conclusion of arrangements the itemized statement shall be signed by the purchaser and the funeral director.

**100.7(3)** *Directing of funeral and memorial ceremonies.* If responsible, the funeral director shall perform the following duties:

1. Direct and supervise ceremonies.

2. Direct and supervise final disposition.

#### **645—100.8(142,156) Unclaimed dead human remains for scientific use.**

**100.8(1)** A human remains is unclaimed when:

a. The decedent did not express a desire to be interred, entombed or cremated.

*b.* Relatives or friends of the decedent did not request that the human remains be interred, entombed or cremated.

**100.8(2)** Friend distinguished from casual acquaintance. A friend shall be distinguished from a casual acquaintance by the friend's having been closely associated with the decedent during the decedent's lifetime.

**100.8(3)** Delivery of human remains for scientific purposes. The funeral director, the medical examiner or managing officer of a public health institution, hospital, county home, penitentiary or reformatory shall notify the state department of public health as soon as any human remains, which are unclaimed and may be suitable for scientific purposes, shall come into their custody.

**100.8(4)** Department instructions. When the department of public health receives notice, the funeral director shall be instructed as to the proper disposition of the human remains.

**100.8(5)** Expenses incurred by funeral director. The expenses incurred by the funeral director for the transportation of the human remains to a medical college shall be paid by the medical college receiving the human remains.

**645—100.9(144) Disinterments.** A funeral director in charge of a disinterment shall ensure that the disinterment is performed in accordance with rules promulgated by the Iowa department of public health and shall first secure a disinterment application issued by the Iowa department of public health.

1. No person shall disinter a human remains or cremated remains unless the funeral director, in charge of the disinterment, has a numbered disinterment application which has been issued by the department of public health or by an order of the district court of the county in which the human remains or cremated remains are interred or entombed.

2. All disinterment applications shall be requested and provided by the department of public health.

3. All disinterment applications shall be signed by the authorizing person.

4. Disinterment applications shall be furnished upon request from the department of public health and will remain valid for 30 days after issuance.

5. Disinterment numbers will only be issued to the funeral director, and the disinterment must be done under the direct supervision of the funeral director.

6. Disinterment applications and numbers shall be required for any relocation of a human remains or cremated remains from the original site of interment or entombment.

7. No disinterment application or number is necessary to remove a human remains or cremated remains from a holding facility for interment or entombment in the same cemetery where being temporarily held.

**645—100.10(156) Cremation of human remains and fetuses.**

**100.10(1)** *Record keeping.*

*a.* Delivery receipt. When a human remains is delivered to a crematory, the crematory shall furnish to the delivery person a delivery receipt containing:

(1) The name, address, age, gender, and cause of death of the human remains that are delivered to the crematory.

(2) The date and time of delivery and the type of container that contains the human remains.

(3) If applicable, the name of the funeral director who sent the human remains and the name and license number of the funeral director's associated funeral establishment.

(4) The signature of the person who delivered the human remains.

(5) The signature of the person receiving the human remains on behalf of the crematory.

(6) The name and business address of the crematory establishment.

The crematory shall retain a copy of this receipt in its permanent records.

*b.* Receiving receipt. The crematory authority shall furnish to any person who receives the cremated remains from the crematory a receiving receipt containing:

(1) The name of the decedent whose cremated remains are released from the crematory.

(2) The date and time when the cremated remains were released from the crematory.

(3) The name of the person to whom the cremated remains are released and the name and license number of the funeral establishment, cemetery, family or other person or entity with which they are affiliated.

(4) The signature of the person who receives the cremated remains.

(5) The signature of the person who released the cremated remains on behalf of the crematory.

(6) The name of the crematory operator and the date and time of the cremation.

The crematory shall retain a copy of this receipt in its permanent records.

c. Permanent record. A crematory shall maintain at its place of business a permanent record that includes the following:

(1) Name of deceased person.

(2) Date and time of the cremation.

(3) Copies of the delivery receipt and the receiving receipt.

(4) Disposition of the cremated remains.

(5) Cremation authorization.

(6) Permit for cremation from a medical examiner if required in jurisdiction of death.

**100.10(2) *Employment of a funeral director by a crematory.*** No aspect of these rules shall be construed to require a funeral director to supervise or perform any functions at a crematory not otherwise required by law to be performed by a funeral director. The crematory establishment shall contract only with a licensed funeral establishment and shall not contract directly with the general public.

**100.10(3) *Authorizing person and preneed cremation arrangements.*** The authorized person has legal authority and may make decisions regarding the final disposition of the decedent.

**100.10(4) *Authorization to cremate.***

a. The crematory shall have the authority to cremate human remains upon the receipt of the following:

(1) Cremation authorization form signed by the authorizing person. The cremation authorization form shall contain the following:

1. The name, address, age and gender of the decedent whose human remains are to be cremated.

2. The date, time of death and cause of death of the decedent.

3. The name and license number of the funeral establishment and of the funeral director who obtained the cremation authorization form signed by the authorizing person.

4. The signature of the funeral director.

5. The name and address of the crematory authorized to cremate the human remains.

6. The name and signature of the authorizing person granting permission to cremate the human remains and the authorizing person's relationship to the decedent.

7. A representation that the authorizing person has the right to authorize the cremation of the decedent in accordance with this rule.

8. A representation that in the event there is another person who has superior priority right to that of the authorizing person, the authorizing person has made all reasonable efforts to contact that person and has no reason to believe that the person would object to the cremation of the decedent.

9. A representation that the human remains do not contain any material or implants that may be potentially hazardous to equipment or persons performing the cremation.

10. A representation that the authorizing person has made a positive identification of the decedent or, if the authorizing person is unavailable or declines, there are alternative means of positive identification.

11. The name of the person, funeral establishment or funeral establishment's designee to which the cremated remains are to be released.

12. The manner of the final disposition of the cremated remains.

13. A listing of all items of value and instructions for their disposition.

(2) Permit for cremation from a medical examiner if required in jurisdiction of death.

(3) Any other documentation required by this state.

b. If the authorizing person is not available to execute the cremation authorization form in person, the funeral director may accept written authorization by facsimile, E-mail, or such alternative written or electronic means the funeral director reasonably believes to be reliable and credible.

c. The authorizing person may revoke the authorization and instruct the funeral director or funeral establishment to cancel the cremation. The crematory shall honor any instructions from a funeral director or funeral establishment under this rule if the crematory receives instructions prior to beginning the cremation.

**100.10(5) Cremation procedures.**

a. A crematory shall cremate human remains within 24 hours of issuance of the delivery receipt as defined in subrule 100.10(1).

b. No crematory shall cremate human remains when it has actual knowledge that the human remains contain a pacemaker or have any other implants or materials which will present a health hazard to those performing the cremation and processing and pulverizing the cremated remains.

c. No crematory shall refuse to accept human remains for cremation because such human remains are not embalmed.

d. Whenever a crematory is unable or unauthorized to cremate human remains immediately upon taking custody of the remains, the crematory shall place the human remains in a holding facility in accordance with the crematory rules and regulations and within the parameters of rules 645—100.5(135,144) and 645—100.6(156).

e. No crematory shall accept human remains unless they are delivered to the crematory in a container which prevents the leakage of body fluids.

f. Under no circumstances shall an alternative container or casket be opened at the cremation establishment except to facilitate proper cremation.

g. The container in which the human remains are delivered to the crematory shall be cremated with the human remains or safely destroyed.

h. The simultaneous cremation of the human remains of more than one person within the same cremation chamber, without the prior written consent of the authorized person, is prohibited. Nothing in this rule, however, shall prevent the simultaneous cremation within the same cremation chamber of body parts delivered to the crematory from multiple sources, or the use of cremation equipment that contains more than one cremation chamber.

i. No unauthorized person shall be permitted in the holding facility or cremation room while any human remains are being held there awaiting cremation, being cremated, or being removed from the cremation chamber.

j. A crematory shall not allow removal of any dental gold, body parts, organs, or any item of value prior to or subsequent to a cremation without previously having received specific written authorization from the authorizing person and written instructions for the delivery of these items to the authorizing person.

k. Upon the completion of each cremation, and insofar as is practicable, all of the recoverable residue of the cremation process shall be removed from the cremation chamber.

l. If all of the recovered cremated remains will not fit within the receptacle that has been selected, the remainder of the cremated remains shall be returned to the authorizing person or this person's designee in a separate container. The crematory shall not return to an authorized person or this person's designee more or less cremated remains than were removed from the cremation chamber.

m. A crematory shall not knowingly represent to an authorized person or this person's designee that a temporary cremation container or urn contains the cremated remains of a specific decedent when it does not.

n. Cremated remains shall be shipped only by a method that has an internal tracing system available and that provides a receipt signed by the person accepting delivery.

o. A crematory shall maintain an identification system that shall ensure the identity of human remains in its possession throughout all phases of the cremation process. A noncombustible tag or disc that includes the name and license number of the crematory and the city and state where the crematory is

located shall be attached to the plastic bag with the cremated remains or placed in amongst the cremated remains.

**100.10(6) *Disposition of cremated remains.*** If responsible, the funeral director shall supervise the final disposition of the cremated remains as follows:

*a.* Cremated remains may be disposed of by placing them in a grave, crypt, or niche; by scattering them in a scattering area as defined in these rules; or they may remain in the personal care and custody of the authorized person. After supervising the transfer of cremated remains to the authorized person or place of final disposition, the funeral director shall be discharged.

*b.* Upon the completion of the cremation process, the crematory shall release the cremated remains to the funeral establishment or the authorized person or the authorized person's designee. Upon the receipt of the cremated remains, the individual receiving them may transport them in any manner in this state without a permit and may dispose of them in accordance with this rule. After releasing the cremated remains, the crematory shall be discharged from any legal obligation or liability concerning the cremated remains.

*c.* If, after a period of 60 days from the date of the cremation, the authorizing person or designee has not instructed the funeral director to arrange for the final disposition of the cremated remains, the funeral director may dispose of the cremated remains in any manner permitted by this rule. The funeral establishment, however, shall keep a permanent record identifying the site of final disposition. The authorizing person shall be responsible for reimbursing the funeral establishment for all reasonable expenses incurred in disposing of the cremated remains. Any entity that was in possession of cremated remains prior to the effective date of these rules may dispose of them in accordance with this rule.

*d.* Except with the express written permission of the authorizing person, no funeral director or cremation establishment shall:

(1) Dispose of cremated remains in a manner or in a location so that the cremated remains are commingled with those of another person. This prohibition shall not apply to the scattering of cremated remains in an area located in a cemetery and used exclusively for those purposes.

(2) Place cremated remains of more than one person in the same temporary cremation container or urn.

**100.10(7) *Scope of rules.*** These rules shall be construed and interpreted as a comprehensive cremation statute, and the provisions of these rules shall take precedence over any existing laws containing provisions applicable to cremation, but that do not specifically or comprehensively address cremation.

**100.10(8) *Establishment rule.*** Rescinded IAB 4/2/03, effective 5/7/03.  
[ARC 9239B, IAB 11/17/10, effective 12/22/10; ARC 1275C, IAB 1/8/14, effective 2/12/14]

**645—100.11(156) Records to be retained by a funeral establishment.** To ensure a permanent record of the licensed activity relating to the custody of each decedent, each funeral director shall create and the funeral establishment shall maintain the records identified in this rule. Funeral directors and funeral establishments shall comply with the rules adopted by the department of public health under Iowa Code section 144.49.

**100.11(1)** At a minimum, the following information, if applicable, relating to each human remains which enters the custody of the establishment/licensee shall be maintained as the permanent record of licensed activity:

*a.* Name of the deceased;

*b.* Date, time, and place of death (institution or other place, city, state, zip);

*c.* Name and address of the person or funeral establishment to whom the dead body or fetus is released;

*d.* Date and from whom the funeral director assumed custody, including the name of the institution or other place of death releasing the dead human body or fetus;

*e.* Date, time, and name of the licensed funeral director or registered intern completing embalming or other preparation for final disposition;

*f.* Date, place and method of final disposition of the dead body or fetus.

**100.11(2)** Each funeral establishment shall create and maintain the following records for a period of ten years:

- a. General price list required by the funeral rule, beginning on the most recent effective date;
- b. Each completed statement of goods and services required by the funeral rule, beginning on the date the statement is signed;
- c. Cremation records (see 645—100.10(156));
- d. Embalming records;
- e. Each preneed contract (pursuant to Iowa Code chapter 523A), beginning on the date of death.

**100.11(3)** The funeral records maintained by the funeral establishment as required in 100.11(1) and 100.11(2) shall be made available by the manager, funeral director or owner of the funeral establishment to:

- a. Any person or entity assuming a new ownership interest or any person newly assuming the position of manager, at least ten days prior to a change in ownership or manager, unless otherwise mutually agreed upon by the parties;
- b. Any licensed funeral director who practiced funeral directing while under the employment of, or while acting as an agent of, the funeral establishment; and
- c. The state registrar of vital statistics and the board.

**100.11(4)** In the event a funeral establishment ceases to do business, the owner or manager of the funeral establishment shall identify the person or entity which will be responsible for records to be maintained by a funeral establishment as required in 100.11(1) and 100.11(2). The funeral establishment shall notify the board if funeral records are moved from the funeral establishment to another location and identify the person responsible for their safekeeping.

[ARC 1274C, IAB 1/8/14, effective 2/12/14]

These rules are intended to implement Iowa Code chapters 147, 156, and 272C.

[Filed prior to 7/1/52; amended 2/24/58, 6/10/60, 3/15/72]

[Filed 4/24/80, Notice 1/9/80—published 5/14/80, effective 7/1/80]

[Filed 8/23/82, Notice 5/26/82—published 9/15/82, effective 10/21/82]

[Filed emergency after Notice 1/19/84, Notice 10/26/83—published 2/15/84, effective 1/19/84]

[Filed 7/13/84, Notice 5/23/84—published 8/1/84, effective 9/5/84]

[Filed 1/24/86, Notice 12/18/85—published 2/12/86, effective 3/20/86]

[Filed 8/30/88, Notice 6/29/88—published 9/21/88, effective 10/26/88]

[Filed 1/17/92, Notice 9/4/91—published 2/5/92, effective 3/11/92]

[Filed 4/24/92, Notice 3/4/92—published 5/13/92, effective 6/17/92]

[Filed 1/27/95, Notice 10/26/94—published 2/15/95, effective 3/22/95<sup>1</sup>]

[Filed 5/2/97, Notice 2/26/97—published 5/21/97, effective 6/25/97]

[Filed 8/20/97, Notice 7/2/97—published 9/10/97, effective 10/15/97]

[Filed 8/18/98, Notice 5/6/98—published 9/9/98, effective 10/14/98]

[Filed 6/19/02, Notice 1/9/02—published 7/10/02, effective 8/14/02]

[Filed 3/13/03, Notice 1/8/03—published 4/2/03, effective 5/7/03]

[Filed 3/23/05, Notice 2/16/05—published 4/13/05, effective 5/18/05]

[Filed 12/9/05, Notice 9/28/05—published 1/4/06, effective 2/8/06]

[Filed 3/9/06, Notice 1/4/06—published 3/29/06, effective 5/3/06]

[Filed 3/21/08, Notice 1/16/08—published 4/9/08, effective 5/14/08]

[Filed 9/12/08, Notice 7/30/08—published 10/8/08, effective 11/12/08]

[Filed ARC 9239B (Notice ARC 8927B, IAB 7/14/10), IAB 11/17/10, effective 12/22/10]

[Filed ARC 1274C (Notice ARC 1163C, IAB 10/30/13), IAB 1/8/14, effective 2/12/14]

[Filed ARC 1275C (Notice ARC 1164C, IAB 10/30/13), IAB 1/8/14, effective 2/12/14]

<sup>1</sup> Effective date of 645—100.1(4)“a,” 100.1(5)“c,” 100.1(8)“a,” 100.6(135,144) and 100.7(135,144) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 13, 1995; delay lifted by this Committee May 9, 1995.

CHAPTER 101  
LICENSURE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS, AND  
CREMATION ESTABLISHMENTS

[Prior to 9/21/88, see Health Department[470] Ch 147]

[Prior to 7/10/02, see 645—100.9(156) and 645—100.10(156)]

**645—101.1(156) Definitions.** For purposes of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Board*” means the board of mortuary science.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Licensee*” means any person licensed to practice as a funeral director in the state of Iowa.

“*License expiration date*” means the fifteenth day of the birth month every two years following initial licensure.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice mortuary science to an applicant who is or has been licensed in another state.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 645—101.18(17A,147,272C) by which an inactive license is restored to active status.

“*Reciprocal license*” means the issuance of an Iowa license to practice mortuary science to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board of mortuary science to license persons who have the same or similar qualifications to those required in Iowa.

“*Reinstatement*” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

**645—101.2(156) Requirements for licensure.** The following criteria shall apply to licensure:

**101.2(1)** The applicant shall complete a board-approved application packet. Application forms may be obtained from the board’s Web site (<http://www.idph.state.ia.us/licensure>) or directly from the board office. All applications shall be sent to Board of Mortuary Science, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**101.2(2)** The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

**101.2(3)** Each application shall be accompanied by the appropriate fees payable to the Board of Mortuary Science. The fees are nonrefundable.

**101.2(4)** No application will be considered by the board until official copies of academic transcripts showing the completion of training in a college of mortuary science approved by the Iowa board of mortuary science have been sent directly from the school to the board.

**101.2(5)** Licensees who were issued their initial licenses within six months prior to the renewal shall not be required to renew their licenses until the renewal month two years later.

**101.2(6)** Incomplete applications that have been on file in the board office for more than two years shall be:

- a. Considered invalid and shall be destroyed; or
- b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

**645—101.3(156) Educational qualifications.**

**101.3(1)** The applicant shall be issued a license to practice mortuary science by the board when the applicant has successfully completed:

*a.* A minimum of 60 hours as indicated on the transcript from a regionally accredited college or university with a minimum of a 2.0 or “C” grade point average. The 60 semester hours shall not include any technical mortuary science courses; and

*b.* A program in mortuary science from a school accredited by the American Board of Funeral Service Education.

*c.* A college course of at least one semester hour or equivalent in current Iowa law and rules covering mortuary science content areas including but not limited to Iowa law and rules governing the practice of mortuary science, cremation, vital statistics, cemeteries and preneed.

**101.3(2)** Foreign-trained funeral directors shall:

*a.* Provide an equivalency evaluation of their educational credentials by International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665, telephone (310)258-9451, Web site [www.ierf.org](http://www.ierf.org), or E-mail at [info@ierf.org](mailto:info@ierf.org). The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

*b.* Provide a notarized copy of the certificate or diploma awarded to the applicant from a mortuary science program in the country in which the applicant was educated.

*c.* Receive a final determination from the board regarding the application for licensure.

*d.* Successfully complete a college course of at least one semester hour or equivalent in current Iowa law and rules covering mortuary science content areas including but not limited to Iowa law and rules governing the practice of mortuary science, cremation, vital statistics, cemeteries and preneed.

[ARC 9239B, IAB 11/17/10, effective 12/22/10]

**645—101.4(156) Examination requirements.**

**101.4(1)** The board shall accept a certificate of examination issued by the International Conference of Funeral Service Examining Boards, Inc., indicating a passing score on both the arts and sciences portions of the examination.

**101.4(2)** Prior to being registered as an intern in Iowa, an applicant shall successfully complete a college course of at least one semester hour or equivalent in current Iowa law and rules covering mortuary science content areas including but not limited to Iowa law and rules governing the practice of mortuary science, cremation, vital statistics, cemeteries and preneed.

[ARC 9239B, IAB 11/17/10, effective 12/22/10]

**645—101.5(147,156) Internship and preceptorship.**

**101.5(1)** *Internship.*

*a.* The intern must serve a minimum of one year of internship under the direct supervision of an Iowa board-certified preceptor. The beginning and ending dates of the internship shall be indicated on the internship certificate. The intern shall engage in the practice of mortuary science only during the time indicated on the internship certificate.

*b.* The intern shall, during the internship, be a full-time employee with the funeral establishment at the site of internship except as provided in paragraph 101.5(2)“j.”

*c.* No licensed funeral director shall permit any person in the funeral director’s employ or under the funeral director’s supervision or control to serve an internship in funeral directing unless that person has a certificate of registration as a registered intern from the department of public health. The registration shall be posted in a conspicuous place in the intern’s primary place of practice.

*d.* No licensed funeral director or licensed funeral establishment shall have more than one intern funeral director for the first 100 human remains embalmed or funerals conducted per year, and with a maximum of two interns per funeral establishment.

*e.* Registered interns shall not advertise or hold themselves out as funeral directors or use the degree F.D. or any other title or abbreviation indicating that the intern is a funeral director.

*f.* The intern shall, during the internship, complete the requirements outlined in 101.5(3), including to embalm not fewer than 25 human remains and direct or assist in the direction of not fewer than 25 funerals under the direct supervision of the certified preceptor and to submit reports on forms furnished by the department of public health. Work on the first 5 embalming cases, first 5 funeral arrangements, and first 5 funeral or memorial services must be completed in the physical presence of the preceptor. The first 12 embalming cases and the first 12 funeral case reports must be completed and submitted by the completion of the sixth month of the internship.

*g.* Before being eligible for licensure, the intern must have filed the 25 completed embalming and funeral directing case reports and a 6-month and a 12-month evaluation form with the department of public health.

*h.* When, for any valid reason, the board determines that the education a registered intern is receiving under the supervision of the present preceptor might be detrimental to the intern or the profession at large, the intern may be required to serve the remainder of the internship under the supervision of a licensed funeral director who is approved by the board.

*i.* The length of an internship may be extended if the board determines that the intern requires additional time or supervision in order to meet the minimum proficiency in the practice of mortuary science.

*j.* The board views a one-year internship completed in a consecutive 12-month period as the best training option. If an internship is interrupted, the internship must be completed within 24 months of the date it started in order to be readily accepted by the board. Internships that are not completed within 24 months shall be preapproved by the board on such terms as the board deems reasonable under the circumstances. The board may require any or all of the following:

(1) Completion of a college course or continuing education course covering mortuary science laws and rules;

(2) Additional case reports;

(3) Extension of an internship up to an additional 12 months depending on such factors as the number of months completed during the internship, length of time that has lapsed since the intern was actively involved in the internship program, and the experience attained by the intern.

*k.* Application for change of preceptor or any other alteration must be made in writing and approval granted by the board before the status of the intern is altered.

*l.* The intern shall complete on a form provided by the board a confidential evaluation of the preceptorship program at the end of the internship. This form shall be submitted before the funeral director's license is issued to the intern.

*m.* The intern must be approved and licensed following a successful internship before the intern may practice mortuary science.

**101.5(2) Preceptorship.**

*a.* A preceptor must have completed a training course within five years prior to accepting an intern. This training course shall cover Iowa law and rule content areas, including but not limited to Iowa law and rules governing licensure and the practice of mortuary science and human resource issues. The training course may be counted toward the continuing education hours required for the licensure biennium in which the training course was completed.

*b.* Any duly Iowa-licensed funeral director who has been practicing for a minimum of five years and who has not had any formal disciplinary action within the past five years with the board of mortuary science and has completed a preceptor training course detailed in paragraph 101.5(2) "a" will be eligible to be a preceptor.

*c.* The preceptor shall be affiliated with a funeral establishment that has not had any formal disciplinary action within the past five years.

*d.* The preceptor is required to file a progress report of the intern that has been signed by both the preceptor and the intern on a board-prescribed form. The 6-month progress report form shall be submitted to the board by the end of the sixth month. The 12-month progress report form shall be submitted to the board by the end of the twelfth month.

*e.* The preceptor shall certify that the intern engages in the practice of mortuary science only during the time frame designated on the official intern certificate.

*f.* A preceptor's duties shall include the following:

- (1) Ensure the intern completes the training program outlined in 101.5(3);
- (2) Be physically present and supervise the first five embalming cases, first five funeral arrangements, and first five funeral or memorial services;
- (3) Familiarize the intern in the areas specified by the preceptor training outline;
- (4) Read, add appropriate comments, and sign each of the 25 embalming reports and the 25 funeral directing reports completed by the intern;

(5) Complete a written six-month report of the intern on a form provided by the board. This report is to be reviewed with and signed by the intern and submitted to the board before the end of the seventh month; and

(6) At the end of the internship, complete a confidential evaluation of the intern on a form provided by the board. This evaluation shall be submitted within two weeks of the end of the internship.

*g.* Failure of a preceptor to fulfill the requirements set forth by the board, including failure to remit the required six-month progress report, as well as the final evaluation, shall result in an investigation of the preceptor by the board and may result in actions which may include, but not be limited to, the loss of preceptor status for current and future interns or discipline or both.

*h.* If a preceptor does not serve the entire year, the board will evaluate the situation; and if a certified preceptor is not available, a licensed funeral director may serve with the approval of the board.

*i.* No licensed funeral director or licensed funeral establishment shall have more than one intern funeral director for the first 100 human remains embalmed or funerals conducted per year, and with a maximum of two interns per funeral establishment.

*j.* With prior board approval, an intern may serve under the supervision of more than one preceptor under the following terms and conditions:

- (1) A single preceptor must act in the role of the primary preceptor.
- (2) The primary preceptor is responsible for coordinating all intern training and activities.
- (3) The intern shall be a full-time employee of the funeral establishment of the primary preceptor; however, compensation may be shared between preceptors.

(4) The primary preceptor may make arrangements with a maximum of two additional preceptors to share preceptor responsibilities for such purposes as providing an intern with a higher volume practice or a broader range of intern experiences.

(5) Each preceptor shall be individually responsible for directly supervising the intern's activities performed under the preceptor's guidance, but the primary preceptor remains responsible for coordinating the intern's activities and submitting all forms to the board.

**101.5(3) Intern training requirements.**

*a.* The board-approved preceptor shall ensure that the intern is knowledgeable of each of the following items during the internship:

- (1) The requirements of the Federal Trade Commission.
- (2) The requirements of the Occupational Safety and Health Act.
- (3) The requirements of the Americans With Disabilities Act.
- (4) The benefits of the Social Security and Veterans Health Administrations.
- (5) The requirements of Iowa funeral law and forms (for example, preneed in Iowa Code chapter 523A, death certificates and Iowa burial transit permits in Iowa Code chapter 144, authorized person in Iowa Code chapter 144C and the board's laws and rules).

*b.* The board-approved preceptor shall ensure that the intern performs each of the following under the preceptor's direct supervision:

- (1) Assists with or performs a minimum of 10 transfers of human remains.
- (2) Performs 25 embalming of human remains to include:
  1. Obtaining permission to embalm.
  2. Placement of human remains on preparation table.
  3. Pre-embalming analysis.

4. Primary disinfection.
5. Setting features.
6. Selection of injection/drainage sites and raising those vessels.
7. Selection and mixing of embalming chemicals and operation of the embalming machine.
8. Injection and drainage methods.
9. Cavity treatment.
10. Suturing techniques.
- (3) Prepares a minimum of 10 human remains for viewing to include:
  1. Dressing.
  2. Cosmetizing.
  3. Casketing.
- (4) Assists with cremation procedures to include:
  1. Contacting medical examiner.
  2. Completing required cremation forms.
  3. Preparing remains for cremation.
- (5) Makes complete funeral arrangements with a minimum of 10 families to include each of the following, as applicable:
  1. Presentation of funeral goods, products and services.
  2. Presentation of payment options for families.
  3. Contacting third-party suppliers of goods and services, such as clergy, cemetery personnel, outer burial container provider, crematory, florist, and musicians.
  4. Completing the obituary.
  5. Presentation of general price list and associated price lists.
  6. Preparation and presentation of statement of funeral goods and services.
- (6) Coordinates, at a minimum, 10 visitations to include:
  1. Preparing the chapel, visitation room or other facility.
  2. Setting up floral arrangements.
  3. Setting up register book and memorial folders or prayer cards.
- (7) Directs a minimum of 25 funerals or memorial services to include, as applicable:
  1. Greeting funeral attendees.
  2. Assisting casket bearers.
  3. Preparing for funeral procession.
  4. Driving a vehicle in procession.
  5. Assisting at graveside committal.
  6. Transporting flowers.
  7. Coordinating with officiant and family.

[ARC 9239B, IAB 11/17/10, effective 12/22/10; ARC 1274C, IAB 1/8/14, effective 2/12/14]

#### **645—101.6(156) Student practicum.**

**101.6(1)** A student may participate in a student practicum in a licensed funeral establishment in Iowa if the student's school is accredited by and in good standing with the American Board of Funeral Service Education (ABFSE). The student practicum must meet the requirements of the ABFSE.

**101.6(2)** Students serving a practicum in Iowa shall be under the direct physical supervision of a funeral director who meets the following requirements:

- a. Has completed the Iowa preceptor training course within the immediately preceding five years.
- b. Has not had any formal disciplinary action within the past five years.
- c. Is affiliated with a funeral establishment that has not had formal disciplinary action within the past five years.

**645—101.7(156) Funeral establishment license or cremation establishment license or both establishment licenses.**

**101.7(1)** A place of business devoted to providing any aspect of mortuary science or cremation services shall hold an establishment license issued by the board. An establishment license shall not be issued more than 30 days prior to the opening of a new establishment.

*a.* A funeral establishment, a cremation establishment, or a combined funeral and cremation establishment shall not be operated until it has obtained a license from the board. Such an establishment shall timely renew the license in order to continue operations.

*b.* A funeral or cremation establishment shall surrender its license to the board if it fails to engage in or ceases to engage in the business for which the license was issued, pursuant to Iowa Code section 156.15(2)“*d.*”

*c.* A funeral or cremation establishment license is not transferable or assignable.

*d.* A change in ownership shall require the issuance of a new license. A change in ownership shall be reported to the board prior to the date ownership will change or, in the case of change of ownership by death or other unexpected event, within 30 days following change of ownership. The board may request legal proof of the ownership transfer. A change in ownership shall be defined as any change of controlling interest in any corporation or other business entity.

*e.* An establishment license shall be issued for a specific physical location. A change in location or site of an establishment shall require the submission of an application for a new license and payment of the fee required by 645—subrule 105.1(9). A new establishment license must be issued prior to the commencement of business in a new location.

*f.* A change in the name of an establishment shall be reported to the board within 30 days. The establishment owner shall pay the fee for reissuing the certificate.

*g.* A change in address or of the funeral director in responsible charge shall be reported to the board within 30 days.

*h.* An establishment shall have an employment or other relationship with one or more licensed funeral directors who shall perform all mortuary science services for which licensure as a funeral director is required by Iowa Code chapter 156. A cremation establishment is not, however, required to employ or contract with a funeral director on an ongoing basis because a cremation establishment shall not offer services directly to the general public. When a funeral establishment has an employment or other relationship with multiple funeral directors, the funeral establishment shall designate the funeral director who shall be in responsible charge of all mortuary science services performed at the funeral establishment. The funeral establishment shall report to the board any change of the funeral director in responsible charge within 30 days of the change.

*i.* Rescinded IAB 10/8/08, effective 11/12/08.

*j.* The board shall not routinely issue more than one establishment license for a single location, but the board may do so if the multiple applicants provide proof, satisfactory to the board, that the establishments are wholly separate except for the sharing of facilities. If the board issues more than one establishment license for a single location, the licensees shall ensure that the public will not be confused or deceived as to the establishment with which the public is interacting. A facility may have a funeral establishment license and a separate cremation establishment license at a single location.

*k.* The establishment license shall be displayed in a conspicuous place at the location of the establishment.

*l.* Failure to comply with any of these rules shall constitute grounds for discipline pursuant to 645—Chapter 103 or civil penalties for unlicensed practice pursuant to 645—Chapter 104.

**101.7(2)** A funeral establishment, cremation establishment, or both establishments shall be subject to applicable local, state and federal health and environmental requirements and shall obtain all necessary licenses and permits from the agencies with jurisdiction.

**101.7(3)** License application. An application for a funeral establishment license, cremation establishment license, or both establishment licenses shall be in writing on forms furnished by the board and shall be accompanied by the funeral or cremation establishment fee. The application shall contain all of the following:

- a. The name, mailing address and telephone number of the applicant.
- b. The physical location of the establishment.
- c. The mailing address, telephone number, fax and E-mail address of the establishment.
- d. The name, home address and telephone number of the individual in charge who has the authority and responsibility for the establishment's compliance with laws and rules pertaining to the operation of the establishment.
- e. The name and address of all owners and managers of the establishment (e.g., sole proprietor, partner, director, officer, managing partner, member, or shareholder with 10 percent or more of the stock).
- f. The legal name of the establishment and all trade names, assumed names, or other names used by the establishment.
- g. The signature of the responsible authority at the site of the establishment and an acknowledgment of the funeral director in responsible charge of mortuary science services at the funeral establishment that the funeral director is aware of and consents to the designation.
- h. The names and license numbers of all funeral directors employed by or associated with the establishment through contract or otherwise who provide mortuary science services at or for the establishment. When a funeral establishment has an employment or other relationship with multiple funeral directors, the funeral establishment shall designate the funeral director who shall be in responsible charge of all mortuary science services performed at the funeral establishment. No funeral establishment shall be issued a license if it fails to designate the funeral director in responsible charge of the mortuary science services to be performed at the establishment.
- i. All felony or misdemeanor convictions of the applicant and all owners and managing officers of the applicant (except minor traffic offenses with fines of less than \$500).
- j. All disciplinary actions against any professional or occupational license of the applicant by any jurisdiction including, but not limited to, disciplinary action by the Iowa insurance division under Iowa Code chapter 523A or 523I, or action by the Federal Trade Commission.
- k. Further information that the board may reasonably require, such as whether the establishment includes a preparation room.

**645—101.8(156) Licensure by endorsement.** An applicant who has been a licensed funeral director under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. Applicants licensed before 1980 are exempt from showing a passing grade on the national board examination. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

- 101.8(1)** Submits to the board a completed application.
- 101.8(2)** Pays the licensure fee.
- 101.8(3)** Shows evidence of licensure requirements that are similar to those required in Iowa.
- 101.8(4)** Provides official copies of the academic transcripts showing the completion of a mortuary science program accredited by the American Board of Funeral Service Education.
- 101.8(5)** Provides official transcript of grades showing 60 semester hours from a regionally accredited college or university with a minimum of a 2.0 or "C" grade point average.
- 101.8(6)** Completes a college course of at least one semester hour or equivalent in current Iowa law and rules covering mortuary science content areas, including but not limited to Iowa law and rules governing the practice of mortuary science, cremation, vital statistics, cemeteries and preneed.
- 101.8(7)** Furnishes certified evidence of:
  - a. Two or more years of actual practice as a licensed funeral director in the state from which the applicant desires to endorse; or
  - b. Having met requirements substantially equivalent to those in 101.5(1) "g" and 101.5(3).
- 101.8(8)** Was issued the initial license by endorsement within six months of the birth month and will not be required to renew the license until the fifteenth day of the birth month two years later. The new licensee is exempt from meeting the continuing education requirement for the continuing education biennium in which the license was originally issued.

**101.8(9)** Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- a. Licensee's name;
- b. Date of initial licensure;
- c. Current licensure status; and
- d. Any disciplinary action taken against the license.

**101.8(10)** Satisfies the provisions of 101.18(3), if the applicant is not actively licensed in another jurisdiction.

[ARC 9239B, IAB 11/17/10, effective 12/22/10; ARC 1274C, IAB 1/8/14, effective 2/12/14]

**645—101.9(156) Licensure by reciprocal agreement.** Rescinded IAB 10/8/08, effective 11/12/08.

**645—101.10(156) License renewal.**

**101.10(1)** The biennial license renewal period for a license to practice as a funeral director shall begin on the sixteenth day of the licensee's birth month and end on the fifteenth day of the licensee's birth month two years later. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license. All licensees shall renew on a biennial basis.

**101.10(2)** An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal date two years later. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The licensee will be required to complete a minimum of 24 hours of continuing education per biennium for each subsequent license renewal, with 2 of the 24 hours covering current Iowa law and rules as identified in 645—paragraph 102.3(2) "f."

**101.10(3)** A licensee seeking renewal shall:

- a. Meet the continuing education requirements of rule 645—102.2(272C). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and
- b. Submit the completed renewal application and renewal fee before the license expiration date.
- c. Persons licensed to practice funeral directing shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

**101.10(4)** Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. 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 or disciplinary investigation.

**101.10(5)** A person licensed to practice as a funeral director shall keep the license certificate displayed in a conspicuous public place at the primary site of practice.

**101.10(6)** 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 645—subrule 105.1(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

**101.10(7)** Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a funeral director in Iowa until the license is reactivated. A licensee who practices as a funeral director in the state of Iowa with an inactive license 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, and other available legal remedies.

[ARC 9239B, IAB 11/17/10, effective 12/22/10; ARC 1275C, IAB 1/8/14, effective 2/12/14]

**645—101.11(147) Duplicate certificate or wallet card.** Rescinded IAB 10/8/08, effective 11/12/08.

**645—101.12(147) Reissued certificate or wallet card.** Rescinded IAB 10/8/08, effective 11/12/08.

**645—101.13(272C) Renewal of a funeral establishment license or cremation establishment license or both establishment licenses.**

**101.13(1)** The renewal cycle shall be triennial beginning July 1 and ending on June 30 of the third year. The renewal shall be:

- a. Submitted on a form provided by the board; and
- b. Accompanied by the renewal fee.

**101.13(2)** Failure to receive notice from the board shall not relieve the license holder of the obligation to pay triennial renewal fees on or before the renewal date.

**101.13(3)** Funeral and cremation establishments shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

**101.13(4)** Late renewal. If the renewal fee and renewal application are received within 30 days after the license renewal expiration date, the late fee for failure to renew before expiration shall be charged.

**101.13(5)** When all requirements for license renewal are met, the licensee shall be sent a license renewal card by regular mail.

[ARC 1275C, IAB 1/8/14, effective 2/12/14]

**645—101.14(272C) Inactive funeral establishment license or cremation establishment license or both establishment licenses.**

**101.14(1)** If the renewal application and fee are not postmarked within 30 days after the license expiration date, the funeral establishment license or cremation establishment license is inactive. To reactivate a funeral establishment license or a cremation establishment license, the reactivation application and fee shall be submitted to the board office.

**101.14(2)** A funeral establishment or a cremation establishment that has not renewed the funeral establishment license or cremation establishment license within the required time frame will have an inactive license and shall not provide mortuary science services until the license is reactivated.

**645—101.15(17A,147,272C) License reinstatement.** For a funeral or cremation establishment license that has been revoked, suspended, or voluntarily surrendered, the owner must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—101.14(272C) prior to offering mortuary science services from that establishment in this state.

**645—101.16(272C) Reinstatement of a funeral establishment license or a cremation establishment license or both establishment licenses.** Rescinded IAB 1/4/06, effective 2/8/06.

**645—101.17(17A,147,272C) License denial.** Rescinded IAB 1/4/06, effective 2/8/06.

**645—101.18(17A,147,272C) License reactivation.** To apply for reactivation of an inactive license, a licensee shall:

**101.18(1)** Submit a reactivation application on a form provided by the board.

**101.18(2)** Pay the reactivation fee that is due as specified in 645—Chapter 105.

**101.18(3)** Provide verification of current competence to practice as a funeral director by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 24 hours of continuing education that meet continuing education standards defined in 645—102.3(156,272C) within two years prior to filing the application for reactivation; and

(3) Verification of completion of 2 hours of continuing education in current Iowa law and rules covering mortuary science content areas including but not limited to Iowa law and rules governing the practice of mortuary science, cremation, vital statistics, cemeteries and preneed. These 2 hours shall be included as a part of the 24 hours required in 101.18(3) “a”(2).

*b.* If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:

1. Licensee’s name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 48 hours of continuing education that meet continuing education standards defined in 645—subrule 102.3(1) and 645—paragraphs 102.3(2) “a,” “b,” “c,” and “e,” within two years prior to filing the application for reactivation. Independent study identified in 645—paragraph 102.3(2) “f” shall not exceed 24 hours of the 48 hours; and

(3) Verification of completion of a college course of at least one semester hour or equivalent in current Iowa law and rules covering mortuary science content areas including but not limited to Iowa law and rules governing the practice of mortuary science, cremation, vital statistics, cemeteries and preneed. [ARC 9239B, IAB 11/17/10, effective 12/22/10]

**645—101.19(17A,147,272C) License reinstatement.** A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—101.18(17A,147,272C) prior to practicing as a funeral director in this state. The owner of a funeral home establishment whose establishment license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the establishment license and must apply for and be granted reactivation of the establishment license prior to reopening the funeral home establishment.

These rules are intended to implement Iowa Code chapters 17A, 147, 156 and 272C.

[Filed prior to 7/1/52]

[Filed 11/9/76, Notice 9/22/76—published 12/1/76, effective 1/5/77]

[Filed 4/7/77, Notice 2/9/77—published 5/4/77, effective 6/8/77]

[Filed 6/9/78, Notice 11/2/77—published 6/28/78, effective 8/2/78]

[Filed 9/29/78, Notice 8/9/78—published 10/18/78, effective 11/22/78]

[Filed 4/11/79, Notice 9/20/78—published 5/2/79, effective 7/1/79]

[Filed emergency 5/23/79—published 6/13/79, effective 7/1/79]

[Filed 4/24/80, Notice 1/9/80—published 5/14/80, effective 7/1/80]

[Filed 4/23/81, Notice 2/4/81—published 5/13/81, effective 6/17/81]

[Filed 12/3/81, Notice 6/10/81—published 12/23/81, effective 2/1/82]

[Filed 8/23/82, Notice 5/26/82—published 9/15/82, effective 10/21/82]

[Filed 10/22/82, Notice 9/15/82—published 11/10/82, effective 12/17/82]

[Filed 2/11/83, Notice 11/10/82—published 3/2/83, effective 4/7/83]

[Filed emergency after Notice 1/19/84, Notice 10/26/83—published 2/15/84, effective 1/19/84]

[Filed 7/13/84, Notice 5/23/84—published 8/1/84, effective 9/5/84]

[Filed 4/15/85, Notice 2/27/85—published 5/8/85, effective 6/12/85]

[Filed 1/10/86, Notice 7/17/85—published 1/29/86, effective 3/6/86]◊

[Filed 8/30/88, Notice 6/29/88—published 9/21/88, effective 10/26/88]  
 [Filed 12/8/89, Notice 10/4/89—published 12/27/89, effective 1/31/90]  
 [Filed 2/12/90, Notice 11/1/89—published 3/7/90, effective 4/11/90]  
 [Filed 7/6/90, Notice 3/21/90—published 7/25/90, effective 9/25/90]  
 [Filed 4/26/91, Notice 3/6/91—published 5/15/91, effective 6/19/91]  
 [Filed 6/21/91, Notice 5/15/91—published 7/10/91, effective 8/14/91]  
 [Filed 1/17/92, Notice 9/4/91—published 2/5/92, effective 3/11/92]  
 [Filed 4/24/92, Notice 3/4/92—published 5/13/92, effective 6/17/92]  
 [Filed 8/27/93, Notice 5/26/93—published 9/15/93, effective 10/20/93]  
 [Filed 6/17/94, Notice 3/2/94—published 7/6/94, effective 8/10/94]  
 [Filed 1/27/95, Notice 10/26/94—published 2/15/95, effective 3/22/95<sup>1</sup>]  
 [Filed 5/18/95, Notice 2/15/95—published 6/7/95, effective 7/12/95]  
 [Filed 10/6/95, Notice 7/19/95—published 10/25/95, effective 11/29/95]  
 [Filed 1/19/96, Notice 10/25/95—published 2/14/96, effective 3/20/96]  
 [Filed 8/18/98, Notice 5/6/98—published 9/9/98, effective 10/14/98]  
 [Filed 4/21/99, Notice 1/13/99—published 5/19/99, effective 6/23/99]  
 [Filed 4/21/99, Notice 3/10/99—published 5/19/99, effective 6/23/99]  
 [Filed 6/11/99, Notice 4/7/99—published 6/30/99, effective 8/4/99]  
 [Filed 10/13/00, Notice 9/6/00—published 11/1/00, effective 12/6/00]  
 [Filed 6/19/02, Notice 1/9/02—published 7/10/02, effective 8/14/02]  
 [Filed 9/9/04, Notice 7/7/04—published 9/29/04, effective 11/3/04]  
 [Filed 6/15/05, Notice 4/13/05—published 7/6/05, effective 8/10/05]<sup>◇</sup>  
 [Filed 12/9/05, Notice 9/28/05—published 1/4/06, effective 2/8/06]<sup>◇</sup>  
 [Filed 6/9/06, Notice 4/12/06—published 7/5/06, effective 8/9/06]  
 [Filed 3/21/08, Notice 1/16/08—published 4/9/08, effective 5/14/08]  
 [Filed 9/12/08, Notice 7/30/08—published 10/8/08, effective 11/12/08]  
 [Filed ARC 9239B (Notice ARC 8927B, IAB 7/14/10), IAB 11/17/10, effective 12/22/10]  
 [Filed ARC 1274C (Notice ARC 1163C, IAB 10/30/13), IAB 1/8/14, effective 2/12/14]  
 [Filed ARC 1275C (Notice ARC 1164C, IAB 10/30/13), IAB 1/8/14, effective 2/12/14]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> Effective date of 645—101.3(147,156), 101.98(3), 101.212(16) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 13, 1995; delay lifted by this Committee May 9, 1995.



## **TRANSPORTATION DEPARTMENT[761]**

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 144  
AUTOMATED TRAFFIC ENFORCEMENT ON THE PRIMARY ROAD SYSTEM

**761—144.1(307) Purpose.** The purpose of this chapter is to establish requirements, procedures, and responsibilities in the use of automated traffic enforcement systems on the primary road system. This chapter ensures consistency statewide in the use of automated traffic enforcement systems on the primary road system and pertains to fixed and mobile automated enforcement.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.2(307) Contact information.** Information relating to this chapter may be obtained from the Office of Traffic and Safety, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.3(307) Definitions.** As used in this chapter:

“*Automated enforcement*” means the use of automated traffic enforcement systems for enforcement of laws regulating vehicular traffic.

“*Automated traffic enforcement system*” means a system that operates in conjunction with an official traffic-control signal, as described in Iowa Code section 321.257, or a speed measuring device to produce recorded images of vehicles being operated in violation of traffic or speed laws.

“*High-crash location*” means a location where data indicates a greater frequency or higher rate of crashes when compared with other similar locations within the local jurisdiction, other like jurisdictions, or larger metropolitan area.

“*High-risk location*” means a location where the safety of citizens or law enforcement officers would be at higher risk through conventional enforcement methods.

“*Interstate roads*” means the same as defined in Iowa Code section 306.3.

“*Local jurisdiction*” means a city or county.

“*Primary road system*” means the same as defined in Iowa Code section 306.3.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.4(307) Overview.**

**144.4(1) General.**

a. Automated enforcement shall only be considered after other engineering and enforcement solutions have been explored and implemented.

b. An automated traffic enforcement system should not be used as a long-term solution for speeding or red-light running.

c. Automated enforcement should only be considered in extremely limited situations on interstate roads because they are the safest class of any roadway in the state and they typically carry a significant amount of non-familiar motorists.

d. Automated enforcement shall only be considered in areas with a documented high-crash or high-risk location in any of the following:

(1) An area or intersection with a significant history of crashes which can be attributed to red-light running or speeding.

(2) A school zone.

**144.4(2) Applicability.**

a. These rules apply only to local jurisdictions using or planning to use automated enforcement on the primary road system.

b. The department does not have the authority to own or operate any automated traffic enforcement system.

c. The department shall not receive any financial payment from any automated traffic enforcement system owned or operated by a local jurisdiction.

**144.4(3) Department approval.** A local jurisdiction must obtain approval from the department prior to using an automated traffic enforcement system on the primary road system.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.5(307) Automated traffic enforcement system request.**

**144.5(1) Justification report.** A local jurisdiction requesting to use an automated traffic enforcement system on the primary road system shall provide the department a justification report. A licensed, professional engineer knowledgeable in traffic safety shall sign the justification report.

*a.* The justification report shall provide all necessary information and documentation to clearly define the area, provide evidence documenting why the area is a high-crash or high-risk location, and describe the process used to justify the automated traffic enforcement request.

*b.* At a minimum, the justification report shall:

(1) Document existing traffic speeds, posted speed limits, traffic volumes, and intersection or roadway geometry. Provide assurance that existing speed limits and traffic signal timings are appropriate and describe how they were established.

(2) Document applicable crash history, the primary crash types, crash causes, crash severity, and traffic violations. Only crashes attributable to speeding or the running of a red light shall be included in this report. Compare crash data with other similar locations within the local jurisdiction, other like jurisdictions, or larger metropolitan area.

(3) Identify the critical traffic safety issue(s) from the data in subparagraphs 144.5(1)“*b*”(1) and (2) above and provide a comprehensive list of countermeasures that may address the critical traffic safety issue(s).

(4) Document solutions or safety countermeasures that have been implemented along with those that have been considered but not implemented. These may include law enforcement, engineering, public education campaigns, and other safety countermeasures.

(5) Document discussions held and actions taken with partnering agencies that have resources which could aid in the reduction of crashes attributable to speeding or the running of a red light.

(6) Document why the local jurisdiction believes automated enforcement is the best solution to address the critical traffic safety issue(s).

*c.* If the request is for a mobile automated enforcement system, the justification report shall also:

(1) Include a description of the mobile unit.

(2) Include the proposed duration of use at each location and indicate where the unit will be physically placed relative to the curb, shoulder, median, etc.

**144.5(2) Request to department.** The local jurisdiction shall submit a request and a justification report to the appropriate district engineer.

**144.5(3) Department review.** Within 90 days of receipt of the request and a complete justification report, the department will either approve or deny specific automated enforcement locations. The department may need additional response time if collection of data is needed, such as conducting a speed study. Incomplete justification reports will be returned to the local jurisdiction. The department will review the request and justification report, evaluate the process used, and determine if the proposed automated traffic enforcement system is needed and warranted. If approval to proceed is granted to the local jurisdiction, the department shall prepare an agreement which will be signed by the department and the local jurisdiction.

**144.5(4) Public notice.** Once the department receives a request and a complete justification report from a local jurisdiction, the department may notify the public and include information on the department’s Web site.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.6(306,307,318,321) Minimum requirements for automated traffic enforcement systems.** The following minimum requirements must be met for each automated traffic enforcement system.

**144.6(1) Safe environment for motorists.**

*a.* Any fixed or mobile automated traffic enforcement system must not create a potentially unsafe environment for motorists.

*b.* The system shall:

(1) Be installed and maintained in a safe manner.

- (2) Be located where it does not impede, oppose or interfere with free passage along the primary highway right-of-way.
- (3) Be located where it does not create a visual obstruction to passing motorists.
- (4) Not be placed or parked on any shoulder or median of any interstate highway.
- (5) Not be placed or parked within 15 feet of the outside traffic lane of any interstate highway, unless shielded by a crashworthy barrier.
- (6) Not be placed or parked on the outside shoulder of any other primary highway for longer than 48 hours unless shielded by a crashworthy barrier.
- (7) Not be placed or parked within 2 feet of the back of the curb of a municipal extension of any primary road.
- (8) Be placed in a manner to avoid creating traffic backups or delays.
- (9) Not be placed nor operational within the defined limits of any construction or maintenance work zone.
- (10) Not be placed within the first 1,000 feet of a lower speed limit.

**144.6(2) Signage.**

- a. Permanent signs may be posted on primary access roads entering local jurisdictions that use automated enforcement technology.
- b. For all fixed automated traffic enforcement systems, permanent signs shall be posted in advance of the locations where enforcement systems are in use to advise drivers that cameras are in place.
- c. For mobile automated traffic enforcement systems, temporary or permanent signs advising that speed is monitored by automated traffic technology shall be posted in advance of the enforcement area as agreed to by the department and the local jurisdiction.
- d. All signing shall be in accordance with the “Manual on Uniform Traffic Control Devices,” as adopted in 761—Chapter 130.

**144.6(3) Enforcement.**

- a. If used, automated enforcement technology shall be used in conjunction with conventional law enforcement methods, not as a replacement for law enforcement officer contact.
- b. Mobile automated traffic enforcement systems in a vehicle shall be owned and operated by a law enforcement agency, be marked with official decals, and have an “official” license plate affixed to the vehicle.

**144.6(4) Calibration.** Automated traffic enforcement systems require periodic calibration to ensure accuracy and reliability. Calibration shall be conducted by a local law enforcement officer, trained in the use and calibration of the system, at least quarterly for fixed systems and prior to being used at any new location for mobile systems.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.7(307) Evaluation and reporting.**

**144.7(1) Annual evaluation.** Annually, each local jurisdiction with active automated enforcement on Iowa’s primary highway system shall evaluate the effectiveness of its use.

- a. At a minimum, the evaluation shall:
  - (1) Address the impact of automated enforcement technology on reducing speeds or the number of red-light running violations for those sites being monitored.
  - (2) Identify the number and type of collisions at the sites being monitored, listing comparison data for before-and-after years. If the system includes intersection enforcement, only the monitored approaches should be included in the evaluation.
  - (3) Evaluate and document the automated traffic enforcement system’s impact on addressing the critical traffic safety issue(s) listed in the justification report if a justification report was part of the system’s initial approval process.
  - (4) Provide the total number of citations issued for each calendar year the system has been in operation.
  - (5) Certify that the calibration requirements of subrule 144.6(4) have been met.
- b. Reserved.

**144.7(2) Reporting requirements.** The annual evaluation shall be reported to the department's office of traffic and safety at the address listed in rule 761—144.2(307) by May 1 each year following a full calendar year of operation and shall be based on performance for the previous year.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.8(307) Continued use of automated traffic enforcement system.**

**144.8(1) Reevaluation.** The department will utilize information collected from the annual evaluation reports from local jurisdictions to assist in evaluating the continued need for such systems at each location. Continued use will be contingent on the effectiveness of the system, appropriate administration of it by the local jurisdiction, the continued compliance with these rules, changes in traffic patterns, infrastructure improvements, and implementation of other identified safety countermeasures.

**144.8(2) Reserve the right.** The department reserves the right to require removal or modification of a system in a particular location, as deemed appropriate.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

**761—144.9(307) Appeal process.** A local jurisdiction may appeal a decision made by the department as part of this chapter by submitting a written explanation of the issue and any supporting information to the director of transportation. Once the director receives the appeal, the director shall have 30 days to respond. The director's decision is final agency action.

These rules are intended to implement Iowa Code chapter 318 and sections 306.4, 307.12, 321.348 and 321.366.

[ARC 1260C, IAB 1/8/14, effective 2/12/14]

[Filed ARC 1260C (Notice ARC 1037C, IAB 10/2/13), IAB 1/8/14, effective 2/12/14]

CHAPTERS 145 to 149  
Reserved



CHAPTER 26  
CONTESTED CASE PROCEEDINGS\*

[Prior to 9/24/86, Employment Security[370] Ch 6]

[Former 345—6.5(96) and 6.8(96) transferred to 345—9.2(17A,96) and 9.1(17A,96) respectively, IAC 6/10/92]

[Prior to 3/12/97, Job Service Division [345] Ch 6]

**871—26.1(17A,96) Applicability.** The rules in this chapter govern the procedures for contested case proceedings brought pursuant to Iowa Code chapter 96.

**871—26.2(17A,96) Definitions.** Terms defined in the Iowa employment security law and the Iowa administrative procedure Act and which are used in these rules shall have the same meaning as provided by such laws. In addition, the following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

“*Contested case*” means a proceeding defined in Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case in 1998 Iowa Acts, chapter 1202, section 14. It specifically includes any appeal from a determination of a representative of the department or any appeal or request for a hearing by an employer or employing unit from an experience rating, charge determination or other decision affecting its liability. Except as provided in subrule 26.17(5), a final decision of the employment appeal board of the department of inspections and appeals shall constitute final agency action. A presiding officer’s decision shall be the final decision of the department if there is no appeal therefrom to the employment appeal board of the department of inspections and appeals.

“*Party*” means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

“*Presiding officer*” means an administrative law judge employed by the department of workforce development.

**871—26.3(17A,96) Time requirements.**

**26.3(1)** Time shall be computed as provided in Iowa Code section 4.1(22).

**26.3(2)** For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute.

**871—26.4(17A,96) Commencement of unemployment benefits contested case.**

**26.4(1)** An unemployment benefits contested case is commenced with the filing, by mail, facsimile, online or in person, of a written appeal by a party with the appeals bureau of the department. The appeal shall be addressed or delivered to: Appeals Bureau, Department of Workforce Development, 1000 East Grand Avenue, Des Moines, Iowa 50319. An online appeal is filed by completing and submitting an online appeal form available on the Iowa workforce development Web site.

**26.4(2)** An appeal from an initial decision concerning the allowance or denial of benefits shall be filed, by mail, facsimile, online, or in person, not later than ten calendar days, as determined by the postmark or the date stamp, after the decision was mailed to the party at its last-known address and shall state the following:

- a. The name, address and social security number of the claimant;
- b. A reference to the decision from which appeal is taken; and
- c. The grounds upon which the appeal is based.

**26.4(3)** Notwithstanding the provisions of subrule 26.4(2), a contributory employer, which has not previously received a notice of the filing of a valid claim for benefits, may appeal an individual’s eligibility to receive benefits within 30 days from the mailing date of the quarterly statement of benefit charges.

**26.4(4)** Also notwithstanding the provisions of subrule 26.4(2), a reimbursable employer, which has not previously received a notice of the filing of a valid claim for benefits, may appeal an individual’s

\*At its meeting held August 3, 1999, the Administrative Rules Review Committee voted to impose a 70-day delay on amendments published in the July 28, 1999, Iowa Administrative Bulletin as **ARC 9215A**.

eligibility to receive benefits within 15 days from the mailing date of the quarterly billing of benefit charges.

**26.4(5)** Appeals transmitted by facsimile or online which are received by the appeals bureau after 11:59 p.m. Central time shall be deemed filed as of the next regular business day.

[ARC 1276C, IAB 1/8/14, effective 2/12/14]

**871—26.5(17A,96) Commencement of employer liability contested case.**

**26.5(1)** An employer liability contested case is commenced with the filing of a written appeal with the appeals bureau of the department by mail, facsimile, online, or in person. The appeal shall be addressed or delivered to: Appeals Bureau, Department of Workforce Development, 1000 East Grand Avenue, Des Moines, Iowa 50319. An online appeal is filed by completing and submitting an online appeal form available on the Iowa workforce development Web site.

**26.5(2)** An appeal from a decision of the tax section of the department concerning employer status and liability, assessments, contribution (tax) rate, successorship, workers' status, and all questions regarding coverage of a worker or group of workers shall be filed, by mail, facsimile, online, or in person, not later than 30 calendar days, as determined by the postmark or the date stamp, after the decision was mailed to the party at its last-known address and shall set forth the following:

- a. The name, address, and Iowa employer account number of the employer;
- b. The name and title of the person filing the appeal;
- c. A reference to the decision from which the appeal is taken; and
- d. The grounds upon which the appeal is based.

**26.5(3)** Appeals transmitted by facsimile or online which are received by the appeals bureau after 11:59 p.m. Central time shall be deemed filed as of the next regular business day.

[ARC 1276C, IAB 1/8/14, effective 2/12/14]

**871—26.6(17A,96) Notice of hearing.**

**26.6(1)** A telephone or in-person hearing shall not be scheduled before the seventh calendar day after the parties receive notice of the hearing. Notice of hearing shall be sent by first-class mail to all parties at their last-known address and shall include:

- a. The date, time and place of an in-person hearing, or the date and time of a telephone hearing, including instructions for calling the appeals bureau in advance of the hearing to provide the names and telephone numbers of all witnesses; and
- b. The nature of the hearing, including the legal authority and jurisdiction under which the hearing is held; and
- c. A statement of the issues and the applicable sections of the Iowa Code or Iowa Administrative Code; and
- d. A description of who will serve as presiding officer.

**26.6(2)** The seven-day notice of hearing may be waived upon the agreement of the parties.

**26.6(3)** An in-person hearing shall be scheduled in the following workforce development centers: Burlington, Carroll, Cedar Rapids, Creston, Council Bluffs, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Mason City, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo.

**26.6(4)** A hearing shall be scheduled promptly and shall be conducted by telephone unless a party requests that it be held in person. A request for an in-person hearing may be denied if factors such as the distance between the parties, the number of parties or the health of any party makes it impractical or impossible to conduct a fair hearing in person. An in-person hearing may be scheduled at the discretion of the presiding officer to whom the contested case is assigned or, in that presiding officer's absence, the chief administrative law judge of the appeals bureau. The party requesting an in-person hearing will ordinarily be required to travel the greater distance if all parties are not located near the same hearing site. As a matter of discretion, the appeals bureau may schedule an in-person hearing at a regular hearing site approximately equidistant from the parties. In the discretion of the presiding officer to whom the contested case is assigned, witnesses or representatives may be allowed to participate via telephone in an in-person hearing, provided that each party has at least one witness present at the hearing site. When two or more parties are involved, the evidence shall be presented during the same hearing.

**26.6(5)** Whenever it appears that other parties should be joined to dispose of all issues in a contested case, the presiding officer shall so order and shall grant such continuance and hold such additional proceedings, upon notice to all parties, as may be necessary.

**26.6(6)** Any number of appeals involving similar issues of law or fact may be consolidated for hearing so long as no substantial rights of any party would be prejudiced by so doing.

**26.6(7)** Any party may appear in any proceeding. Any partnership, corporation, or association may be represented by any of its members, officers, or a duly authorized representative. Any party may appear by, or be represented by, an attorney-at-law or a duly authorized representative of an interested party.

**26.6(8)** Where a party not attending the hearing will be represented by another person, such person shall submit written proof of such representation, signed by the party such person purports to represent, at least three days before the hearing to the presiding officer.

[ARC 1276C, IAB 1/8/14, effective 2/12/14]

**871—26.7(17A,96) Recusal.**

**26.7(1)** A presiding officer shall withdraw from participation in the hearing or the making of any decision in a contested case if:

*a.* The presiding officer has a personal bias or prejudice concerning a party or a representative of a party;

*b.* The presiding officer has personally investigated, prosecuted or advocated, in connection with that case, the specific controversy underlying the case, or another pending factually related case or pending factually related controversy that may culminate in a contested case involving the same parties;

*c.* The presiding officer 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 the contested case, or a pending factually related contested case or controversy involving the same parties;

*d.* The presiding officer has acted as counsel to any person who is a private party to that proceeding within the past two years;

*e.* The presiding officer 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.* The presiding officer has a spouse or relative within the third degree of relationship that: is a party to the case, or an officer, director or trustee of a party; is a lawyer in the case; is known to have an interest that could be substantially affected by the outcome of the case; or is likely to be a material witness in the case; or

*g.* The presiding officer has any other legally sufficient cause to withdraw from participation in the hearing and decision making in that case.

**26.7(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 general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. 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 as amended by 1998 Iowa Acts, chapter 1202, section 19, and subrule 26.10(7).

**26.7(3)** If the presiding officer knows of information which might reasonably be deemed a basis for recusal but decides recusal is unnecessary, the presiding officer shall submit the relevant information for the record along with a statement of the reasons for declining recusal.

**26.7(4)** If a party asserts disqualification of the presiding officer for any appropriate ground, the party shall file an affidavit pursuant to Iowa Code section 17A.17 as amended by 1998 Iowa Acts, chapter 1202, section 19, as soon as the reason alleged in the affidavit becomes known to the party. If, during the course of a hearing, a party first becomes aware of evidence of bias or other ground for recusal, the party

may move for recusal but must establish the grounds by the introduction of evidence into the record. If the presiding officer determines that recusal is appropriate, the presiding officer shall withdraw. If the presiding officer decides that recusal is not required, the presiding officer shall enter an order to that effect. This order may be the basis of the aggrieved party's appeal from the decision in the case.

**871—26.8(17A,96) Withdrawals and postponements.**

**26.8(1)** An appeal may be withdrawn at any time prior to the issuance of a decision upon the request of the appellant and with the approval of the presiding officer to whom the case is assigned. Requests for withdrawal may be made in writing or orally, provided the oral request is tape-recorded by the presiding officer.

**26.8(2)** A hearing may be postponed by the presiding officer for good cause, either upon the presiding officer's own motion or upon the request of any party in interest. A party's request for postponement may be in writing or oral, provided the oral request is tape-recorded by the presiding officer, and is made not less than three days prior to the scheduled hearing. A party shall not be granted more than one postponement except in the case of extreme emergency.

**26.8(3)** If, due to emergency or other good cause, a party, having received due notice, is unable to attend a hearing or request postponement within the prescribed time, the presiding officer may, if no decision has been issued, reopen the record and, with notice to all parties, schedule another hearing. If a decision has been issued, the decision may be vacated upon the presiding officer's own motion or at the request of a party within 15 days after the mailing date of the decision and in the absence of an appeal to the employment appeal board of the department of inspections and appeals. If a decision is vacated, notice shall be given to all parties of a new hearing to be held and decided by another presiding officer. Once a decision has become final as provided by statute, the presiding officer has no jurisdiction to reopen the record or vacate the decision.

**26.8(4)** A request to reopen a record or vacate a decision may be heard *ex parte* by the presiding officer. The granting or denial of such a request may be used as a grounds for appeal to the employment appeal board of the department of inspections and appeals upon the issuance of the presiding officer's final decision in the case.

**26.8(5)** If good cause for postponement or reopening has not been shown, the presiding officer shall make a decision based upon whatever evidence is properly in the record.

**871—26.9(17A,96) Discovery.**

**26.9(1)** Discovery procedures applicable to civil actions are available to all parties in interest in contested cases.

**26.9(2)** Unless otherwise limited by a protective order, the frequency of use of discovery methods is not limited. Upon application by any adversely affected party or upon the presiding officer's own motion, the presiding officer may order otherwise in the following situations:

- a.* The discovery sought is unduly repetitious, or the information sought may be obtained in another method that is more convenient, less burdensome or less expensive; or
- b.* The party seeking discovery has had prior ample opportunity to obtain the information; or
- c.* The discovery is unduly burdensome or expensive when viewed in the context of the factual issues to be resolved, the limited resources of the parties, and the parties' interest in prompt resolution of the contested case.

**26.9(3)** A party may obtain discovery regarding any matter, not privileged, relevant to the subject matter involved in the contested case, including the existence, description, nature, custody, condition and location of any tangible items and the identity and location of persons having knowledge of discoverable matters. Information may be discovered, even if inadmissible itself, if it appears reasonably calculated to lead to the discovery of admissible evidence. In any event, the names of a party's witnesses, their expected testimony, and exhibits to be offered into evidence may be obtained by discovery.

**26.9(4)** A party who has responded to a request for discovery with a response which was complete and accurate when made need not supplement the response to include information obtained after the response. However, a party must promptly supplement its response to requests for the identity and

location of persons having knowledge of discoverable matters, the identity of each person expected to be called to testify at the hearing, and the party must produce copies of exhibits expected to be offered into evidence at the hearing as such decisions are made. A party must also promptly amend any response if it obtains information establishing that its prior response was incorrect when made or, though correct when made, is no longer correct.

**26.9(5)** No motion relating to discovery, including motions for imposition of sanctions, will be considered unless the moving party alleges that it has made a good-faith but unsuccessful effort to resolve the issues raised in the motion with the opposing party without intervention by the presiding officer.

**26.9(6)** Upon motion by a party or the person from whom discovery is sought or by any person who may be adversely affected thereby, and for good cause shown, the presiding officer before whom the contested case is pending may make any order which justice requires to protect a party or person from oppression or undue burden of expense. Such order may deny the request for discovery or limit terms, conditions, manner and scope thereof.

**26.9(7)** A party may, in accordance with subrule 26.9(5), apply to the presiding officer before whom a contested case is pending for an order compelling discovery if the party upon whom the request has been served fails within a reasonable time to make a complete, good-faith response. After notice to both parties and hearing upon the motion, the presiding officer shall enter an order which denies or compels discovery, which order may be combined with a protective order pursuant to subrule 26.9(6).

**26.9(8)** Upon application by any party or upon the presiding officer's own motion, the presiding officer may impose sanctions for the failure to make discovery; however, sanctions shall not be imposed without prior specific notice from the presiding officer of the contemplated sanction, opportunity to be heard, and, if necessary, further opportunity to cure its failure. The sanctions may include the following:

- a. The granting of a postponement to a party demonstrably prejudiced by the failure;
- b. The exclusion of the testimony of witnesses not identified in response to a specific request for such information;
- c. The exclusion from the record of those exhibits not identified in response to a specific request for such information;
- d. The exclusion of the party from participation in the contested case proceedings;
- e. The dismissal of the party's appeal.

**26.9(9)** Requests for discovery shall be filed with the Appeals Bureau, Department of Workforce Development, 1000 East Grand Avenue, Des Moines, Iowa 50319, for service on other parties and persons. Responses must be filed with the party requesting the discovery within ten days after mailing by the department unless an extension of time in which to comply has been granted by the presiding officer. Requests for discovery received within five days before a scheduled contested case hearing will not be honored in the absence of a request for a postponement showing good cause therefor. A party's inattention to preparation is not good cause for postponement.

[ARC 1276C, IAB 1/8/14, effective 2/12/14]

#### **871—26.10(17A,96) Ex parte communications.**

**26.10(1)** An ex parte communication is an oral or written communication relating directly to the facts or legal questions at issue in a contested case proceeding which is made by a party to the presiding officer to whom the case has been assigned without the knowledge or outside the presence of the other parties and with the object of affecting the outcome of the case.

**26.10(2)** Ex parte communication does not include:

- a. Statements given by the parties to representatives of the department for use in making the initial determination;
- b. Statements contained in a party's appeal from the initial determination;
- c. Statements relating only to procedural or scheduling matters, such as requests for discovery, subpoenas, postponements or withdrawals of appeals;
- d. Requests for clarification of a legal issue involved in a contested case, but only to the extent of requesting information on the applicable law sections and not as to matters of fact.

**26.10(3)** Unless required for the disposition of ex parte matters specifically authorized by statute, no party or its representative shall communicate directly or indirectly with the presiding officer to whom a contested case is assigned, nor shall the presiding officer communicate directly or indirectly with a party or its representative concerning any issue of fact or law in a contested case unless:

*a.* Each party or its representative is given written notification of the communication. Such notification shall contain a summary of the communication, if oral, or a copy of the communication, if written, as well as the time, place and means of the communication.

*b.* After notification, all parties have the right, upon written demand, to respond to the ex parte communication, including the right to be present and heard if an oral communication has not been completed. If the communication is written, or if oral and completed, all other parties have the right, upon written demand, to a special hearing to respond to the ex parte communication.

*c.* Whether or not any party requests the opportunity to respond to an ex parte communication made in violation of Iowa Code section 17A.17(2) as amended by 1998 Iowa Acts, chapter 1202, section 19, the presiding officer shall include such communication in the official record of the contested case.

**26.10(4)** 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.

**26.10(5)** Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible.

**26.10(6)** A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial as to require the presiding officer's recusal. If the presiding officer determines that recusal 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 or disclosed. If the presiding officer determines that recusal is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

**26.10(7)** Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual material has already been or shortly will be disclosed. 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 shortly will be provided to the parties.

**26.10(8)** The presiding officer may impose appropriate sanctions for violations of this rule, including dismissal of an appellant's contested case, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by agency personnel shall be reported to the chief administrative law judge for possible sanctions.

#### **871—26.11(17A,96) Motions.**

**26.11(1)** No technical form for motions is required. Nevertheless, prehearing motions must be in writing, state the grounds for relief and state the relief sought.

**26.11(2)** Any party may file a written response to a motion within five business days after the motion is served, unless the time period is extended or shortened by the presiding officer, who may consider failure to respond within the required time period in the ruling on a motion.

**26.11(3)** The presiding officer may schedule oral arguments on any motion.

**26.11(4)** Motions pertaining to the hearing must be filed and served at least five days prior to the date of the hearing unless there is good cause for permitting later action or the time is lengthened or shortened by the presiding officer.

**871—26.12(17A,96) Prehearing conference.**

**26.12(1)** Any party may request a prehearing conference. A request, or an order for a prehearing conference on the presiding officer's own motion, shall be filed not less than five days prior to the hearing. A prehearing conference shall be scheduled not less than three business days prior to the hearing date. Written notice of the prehearing shall be given by the presiding officer to all parties. For good cause, the presiding officer may permit variance from this rule.

**26.12(2)** Each party shall bring to the prehearing conference:

- a.* A final list of witnesses who the party anticipates will testify at the hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names; and
- b.* A final list of exhibits which the party anticipates will be introduced at the hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

Witness or exhibit lists may be amended subsequent to the prehearing within time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

**26.12(3)** In addition to the requirements of subrule 26.12(2), the parties at a prehearing conference may: enter into stipulations of fact; enter into stipulations on the admissibility of exhibits; identify matters the parties intend to request be officially noticed; and consider any additional matters which will expedite the hearing.

**26.12(4)** Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

**871—26.13(17A,96) Subpoenas and witnesses.**

**26.13(1)** It is the responsibility of the parties to request the attendance of such witnesses they believe have knowledge of the facts in issue in the contested case.

**26.13(2)** Upon the written request of a party in interest received at least three days prior to the date of a hearing, the presiding officer shall issue a subpoena compelling the attendance of a person at the contested case hearing.

**26.13(3)** The written request shall include:

- a.* The name and address of the person to be served;
- b.* A statement of the relevance of the witness's testimony and that it will not repeat or duplicate the testimony of other witnesses; and
- c.* A statement that the witness refuses to testify voluntarily despite the party's request that the person do so.

**26.13(4)** A subpoena duces tecum shall be issued in the manner provided in subrule 26.13(2), except that the request must also state specifically the books, papers, correspondence, memoranda or other records desired.

**26.13(5)** Documents subpoenaed for telephone hearings shall be mailed or faxed to the appeals section prior to the hearing to facilitate the exchange of documents among the parties. Documents subpoenaed for in-person hearings shall be brought to the hearing site at the time of the contested case hearing, unless otherwise ordered by the presiding officer.

**26.13(6)** If the presiding officer deems it appropriate, the person to whom a subpoena is directed shall be notified and given the opportunity to object to the issuance of the subpoena.

*a.* If an objection to the issuance of the subpoena is raised, the presiding officer may, as a matter of discretion, hear and rule on the objection prior to commencing the evidentiary hearing or postpone the evidentiary hearing and schedule a special hearing to receive arguments from all parties concerning the issuance of the subpoena.

*b.* The presiding officer shall issue the subpoena if it is established to the presiding officer's satisfaction that the testimony or document sought is material and relevant, is not unduly repetitious of other evidence already of record or expected to be submitted by any party, and, in the case of the subpoena duces tecum, the records requested do not disclose business secrets or cause undue burden on the party to whom the subpoena is directed.

**26.13(7)** If the subpoena is granted over objection, the aggrieved party may, in accordance with Iowa Code section 17A.19(1), petition the district court for review of the action before proceeding further. The aggrieved party must in that event promptly notify the presiding officer that a petition for judicial review of such order will be filed immediately so that the contested case may be postponed until the court has issued its ruling. Nothing herein shall preclude an aggrieved party from including the granting or denial of a subpoena as grounds for appeal of the presiding officer's decision in the contested case to the employment appeal board of the department of inspections and appeals.

**26.13(8)** Any subpoenaed witness attending a hearing shall be paid \$10 for each day's attendance, and \$5 for each attendance of less than a full day, plus mileage expenses at the rate specified in Iowa Code section 79.9 for each mile actually traveled.

**26.13(9)** If any person to whom a subpoena is directed refuses to honor the subpoena, the appeals section of the department may apply to the appropriate district court for an order to compel the party to obey the subpoena.

**26.13(10)** A party may request the issuance of a subpoena or a subpoena duces tecum to be served in another state. If the presiding officer finds the witness or evidence sought is material, relevant and not available in this state, the presiding officer shall explore the possibility of obtaining it voluntarily. When necessary and upon proper application, the presiding officer shall have a subpoena or a subpoena duces tecum issued to be served by a sister agency in the state in which the witness or evidence is located, compelling the witness to testify or the evidence to be produced.

#### **871—26.14(17A,96) Conduct of hearings.**

**26.14(1)** Each contested case hearing shall be heard and decided by a presiding officer who is an administrative law judge.

*a.* All contested case hearings except as provided in paragraphs "*b*" and "*c*" below shall be heard and decided by an administrative law judge employed by the department of workforce development. The qualifications for administrative law judges employed by the department of workforce development shall be the same as the qualifications for administrative law judges employed by the division of administrative hearings of the department of inspections and appeals.

*b.* All contested case hearings in which the department of workforce development is a party shall be heard and decided by a presiding officer who is an administrative law judge employed by the division of administrative hearings of the department of inspections and appeals.

*c.* The department of workforce development is a party to all contested case hearings in which it is the employer. It is a party to those contested case hearings involving issues of employer liability, employee/independent contractor status, fraudulent overpayment and administrative penalty in which it or any of its employees request the right to participate in the hearing by offering testimony and cross-examining witnesses for other parties.

**26.14(2)** The presiding officer shall inquire fully into the factual matters at issue and shall receive in evidence the sworn testimony of witnesses and physical evidence which are material and relevant to such matters. Upon the presiding officer's own motion or upon the written application of any party, and for good cause shown, the presiding officer may reopen the record for additional material, relevant and nonrepetitious evidence not submitted at the original contested case hearing.

**26.14(3)** The presiding officer shall begin each hearing with a brief statement identifying the parties and issues, outlining the history of the case, advising the parties of their appeal rights and announcing what matters, if any, will be officially noticed. Any party may inspect and use any portion of the administrative file necessary for the presentation of its case. The administrative file may include information from the claimant's files maintained in the agency's computer system.

**26.14(4)** The hearing shall be confined to evidence relevant to the issue or issues stated on the notice of hearing. If, during the course of a hearing, it appears to the presiding officer that a section of the Iowa Code not set forth in the notice of hearing may affect the presiding officer's decision, the presiding officer shall so notify the parties and announce willingness to continue taking testimony on the underlying factual matters if the parties agree to waive on record further notice and make no objection to continuing. If any party objects, the presiding officer shall postpone the hearing and cause new notices of hearing,

containing all relevant issues and law sections, to be sent to the parties. Notwithstanding, voluntary quits and discharges generally shall be construed to constitute the single issue of separation from employment so that evidence of either or both types of separation may be received in a single hearing.

**26.14(5)** If factual issues generally relevant to a party's eligibility or liability for benefits but unrelated to the underlying facts in controversy in the present contested case are exposed, the presiding officer shall not take testimony or evidence on such issue but shall remand the issue to the appropriate section of the department for investigation and preliminary determination.

**26.14(6)** In the event that one or more parties which have received notice for a contested case hearing fail to appear at the time and place of an in-person hearing, the presiding officer may proceed with the hearing. If the appealing party fails to appear, the presiding officer may decide the party is in default and dismiss the appeal. The hearing may be reopened if the absent party makes a request to reopen the hearing under subrule 26.8(3) and shows good cause for reopening the hearing.

*a.* If an absent party arrives for an in-person hearing while the hearing is in session, the presiding officer shall pause to admit the party, summarize the hearing to that point, administer the oath, and resume the hearing.

*b.* If an absent party arrives for an in-person hearing after the record has been closed and after any party which had participated in the hearing has departed, the presiding officer shall not take the evidence of the late party. Instead, the presiding officer shall inquire ex parte as to the reason the party was late. For good cause shown, the presiding officer shall cause notice of hearing to be issued to all parties of record and reopen the record. The record shall not be reopened if the presiding officer does not find a good cause for the party's late arrival.

**26.14(7)** If a party has not responded to a notice of telephone hearing by providing the appeals bureau with the names and telephone numbers of the persons who are participating in the hearing by the scheduled starting time of the hearing or is not available at the telephone number provided, the presiding officer may proceed with the hearing. If the appealing party fails to provide a telephone number or is unavailable for the hearing, the presiding officer may decide the appealing party is in default and dismiss the appeal as provided in Iowa Code section 17A.12(3). The record may be reopened if the absent party makes a request to reopen the hearing under subrule 26.8(3) and shows good cause for reopening the hearing.

*a.* If an absent party responds to the hearing notice while the hearing is in progress, the presiding officer shall pause to admit the party, summarize the hearing to that point, administer the oath, and resume the hearing.

*b.* If a party responds to the notice of hearing after the record has been closed and any party which has participated is no longer on the telephone line, the presiding officer shall not take the evidence of the late party. Instead, the presiding officer shall inquire ex parte as to why the party was late in responding to the notice of hearing. For good cause shown, the presiding officer shall reopen the record and cause further notice of hearing to be issued to all parties of record. The record shall not be reopened if the presiding officer does not find good cause for the party's late response to the notice of hearing.

*c.* Failure to read or follow the instructions on the notice of hearing shall not constitute good cause for reopening the record.

**26.14(8)** The presiding officer shall record all communications with late parties. If the presiding officer does not reopen the record, the decision in the contested case shall state the presiding officer's reason for so doing.

**26.14(9)** Rescinded IAB 1/8/14, effective 2/12/14.

**26.14(10)** Whenever necessary, the presiding officer may require the attendance at a hearing of department employees having knowledge of the facts in controversy or having technical knowledge concerning the issues raised in appeal.

*a.* If the primary issue is the claimant's ability to work, availability for work or work search, the department shall be named as respondent. The presiding officer may call department personnel having knowledge of the facts in controversy as witnesses.

*b.* If the issue on appeal is an offer of or recall to work or a job referral by a local workforce development center, both the employer making the offer or recall and the workforce development center representative making the referral may be witnesses at the hearing.

*c.* If the issue on appeal is the claimant's refusal of employment because of wages, the presiding officer may take the testimony of the workforce development representative having knowledge of prevailing wages in the vicinity. The presiding officer may also obtain testimony and evidence of the hours and other conditions of work for similar jobs in the area.

**26.14(11)** In the discretion of the presiding officer, witnesses may be excluded from the hearing room until called to testify. The presiding officer shall admonish such witnesses not to discuss the case among themselves until after the record has been closed. All witnesses shall be subject to examination by the presiding officer and by all parties.

**26.14(12)** The presiding officer may expel or refuse admittance to any party, witness or other person whose conduct at the hearing is disorderly.

**26.14(13)** If the parties agree that no dispute of material facts exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant material evidence either by stipulation or otherwise as agreed by the parties, without the necessity of a formal evidentiary hearing.

[ARC 1277C, IAB 1/8/14, effective 2/12/14]

#### **871—26.15(17A,96) Evidence.**

**26.15(1)** The presiding officer shall accept testimony and other evidence in accordance with Iowa Code section 17A.14.

**26.15(2)** The parties may stipulate as to all or a portion of the facts at issue in the contested case. The presiding officer may accept the stipulation as establishing the facts of the case or may take additional evidence.

**26.15(3)** Documentary evidence, whether or not verified, may be accepted by the presiding officer. Documentary evidence may be received in the form of copies or excerpts, if the originals are not readily available, provided the copies or excerpts are properly authenticated.

**26.15(4)** Objections to evidentiary offers shall be specific in nature and shall be noted in the record by the presiding officer. The presiding officer may rule immediately or defer ruling until the final decision.

#### **871—26.16(17A,96) Recording costs.**

**26.16(1)** The presiding officer shall electronically record all evidentiary hearings, prehearing conferences and hearings on motions, all of which constitute a part of the record of the contested case. A party may, at its own expense, also record any hearing electronically or by certified shorthand reporter.

**26.16(2)** The appeals bureau of the department of workforce development shall provide a copy of the whole or a part of the record at cost, unless there is further appeal in which event the record shall be provided to all parties at no cost.

[ARC 1276C, IAB 1/8/14, effective 2/12/14]

#### **871—26.17(17A,96) Decisions.**

**26.17(1)** The presiding officer shall issue a written, signed decision as soon as practicable after the closing of the record in a contested case. Each decision shall:

*a.* Set forth the issues, appeal rights, a concise history of the case, findings of essential facts, the reasons for the decision and the actual disposition of the case;

*b.* Be based on the kind and quality of evidence upon which reasonably prudent persons customarily rely for the conduct of their serious affairs, even if none of such evidence would be admissible in a jury trial in the Iowa district court; and

*c.* Be sent by first-class mail to each of the parties in interest and their representatives.

**26.17(2)** In reaching a decision, the presiding officer shall apply relevant portions of the Iowa Code, decisions of the Supreme Court of Iowa, published decisions of the Iowa Court of Appeals, the Iowa Administrative Code and pertinent state and federal court decisions, statutes and regulations.

**26.17(3)** Copies of all presiding officer decisions shall be kept on file for public inspection at the administrative office of the department of workforce development, filed according to hearing (appeal) number and indexed by the social security number of the claimant.

**26.17(4)** A presiding officer's decision allowing benefits shall result in the prompt payment of all benefits due. An appeal shall not stay the payment of benefits. A presiding officer's decision reversing an allowance of benefits shall include a statement of overpayment of benefits erroneously paid.

**26.17(5)** A presiding officer's decision constitutes final agency action in an employer liability contested case.

*a.* Any party in interest may file with the presiding officer a written application for rehearing within 20 days after the issuance of the decision. A request for rehearing is deemed denied unless the presiding officer grants the rehearing request within 20 days after its filing.

*b.* Any party in interest may file a petition for judicial review in the Iowa district court within 30 days after the issuance of the decision or within 30 days after the denial of the request for rehearing.

These rules are intended to implement Iowa Code chapters 17A and 96.

[Filed 10/28/75, Notice 9/22/75—published 11/17/75, effective 12/23/75]

[Filed 4/29/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]

[Filed 12/9/76, Notice 11/3/76—published 12/29/76, effective 2/2/77]

[Filed 9/30/77, Notice 8/24/77—published 10/19/77, effective 11/23/77]

[Filed 5/24/78, Notice 4/5/78—published 6/14/78, effective 7/19/78]

[Filed 2/12/80, Notice 10/31/79—published 3/5/80, effective 4/9/80]

[Filed 7/31/80, Notice 4/30/80—published 8/20/80, effective 9/24/80]

[Filed emergency 4/20/81—published 5/13/81, effective 4/20/81]

[Filed 11/6/81, Notice 5/13/81—published 11/25/81, effective 12/30/81]

[Filed emergency 1/10/84—published 2/1/84, effective 1/10/84]

[Filed 4/27/84, Notice 2/29/84—published 5/23/84, effective 6/28/84]

[Filed 8/24/84, Notice 6/20/84—published 9/12/84, effective 10/17/84]

[Filed emergency 7/1/86—published 7/30/86, effective 7/1/86]

[Filed emergency 9/5/86—published 9/24/86, effective 9/5/86]

[Filed emergency 10/1/86—published 10/22/86, effective 10/1/86]

[Filed 12/8/86, Notice 10/22/86—published 12/31/86, effective 2/4/87]

[Filed emergency 6/12/87—published 7/1/87, effective 7/1/87]

[Filed 9/4/87, Notice 7/1/87—published 9/23/87, effective 10/28/87]

[Filed 3/31/89, Notice 2/22/89—published 4/19/89, effective 5/24/89]

[Filed 5/22/92, Notice 4/15/92—published 6/10/92, effective 7/15/92]

[Filed 10/23/92, Notice 9/16/92—published 11/11/92, effective 12/16/92]

[Transferred from 345—Ch 6 to 871—Ch 26 IAC Supplement 3/12/97]

[Filed 7/2/99, Notice 3/24/99—published 7/28/99, effective 9/1/99<sup>1</sup>]

[Filed ARC 1276C (Notice ARC 1094C, IAB 10/16/13), IAB 1/8/14, effective 2/12/14]

[Filed ARC 1277C (Notice ARC 1095C, IAB 10/16/13), IAB 1/8/14, effective 2/12/14]

<sup>1</sup> Amendments published as **ARC 9215A** delayed 70 days by the Administrative Rules Review Committee at the meeting held August 3, 1999.



**LABOR SERVICES DIVISION[875]**

[Prior to 11/19/97, see Labor Services Division[347]]

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CHAPTER 156  
BIDDER PREFERENCES IN GOVERNMENT CONTRACTING

**875—156.1(73A) Purpose, scope and definitions.** These rules institute administrative and operational procedures for enforcement of the Act. The definitions and interpretations contained in Iowa Code section 73A.21 shall be applicable to such terms when used in this chapter.

“*Act*” means Iowa Code section 73A.21.

“*Affiliate*,” when used with respect to any specified person or entity, means another person or entity that, either directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control or ownership with, such specified person or entity.

“*Commissioner*” means the labor commissioner appointed pursuant to Iowa Code section 91.2, or the labor commissioner’s designee.

“*Division*” means the division of labor of the department of workforce development.

“*Nonresident bidder*” means a person or entity that does not meet the definition of a resident bidder, including any affiliate of any person or entity that is a nonresident bidder.

“*Parent*,” when used with respect to any specified person or entity, means an affiliate controlling such specified person or entity directly or indirectly through one or more intermediaries.

“*Public body*” means the state and any of its political subdivisions, including a school district, public utility, or the state board of regents.

“*Public improvement*” means a building or other construction work to be paid for in whole or in part by the use of funds of the state, its agencies, and any of its political subdivisions and includes road construction, reconstruction, and maintenance projects.

“*Public utility*” includes municipally owned utilities and municipally owned waterworks.

“*Resident bidder*” means a person or entity authorized to transact business in this state and having a place of business for transacting business within the state at which it is conducting and has conducted business for at least three years prior to the date of the first advertisement for the public improvement. If another state or foreign country has a more stringent definition of a resident bidder, the more stringent definition is applicable as to bidders from that state or foreign country.

“*Resident labor force preference*” means a requirement in which all or a portion of a labor force working on a public improvement is a resident of a particular state or country.

“*Subsidiary*,” when used with respect to any specified person or entity, is an affiliate controlled by such specified person or entity directly or indirectly through one or more intermediaries.

[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.2(73A) Reporting of resident status of bidders.**

**156.2(1) Reporting to public body.** When a contract for a public improvement is to be awarded to the lowest responsible bidder, the public body shall request a statement from each bidder regarding the bidder’s resident status. The statement shall be on the form designated by the commissioner. The statement shall require the bidder to certify whether the bidder is a resident bidder or a nonresident bidder. In the case of a resident bidder, the statement shall require the resident bidder to identify each office at which the resident bidder has conducted business in the state during the previous three years and the dates on which the resident bidder conducted business at each office. In the case of a nonresident bidder, the statement shall require the nonresident bidder to identify the nonresident bidder’s home state or foreign country as reported to the Iowa secretary of state, to identify each preference offered by the nonresident bidder’s home state or foreign country, and to certify that, except as set forth on the form, there are no other preferences offered by the nonresident bidder’s home state or foreign country. The statement shall include such additional information as requested by the commissioner. The statement must be signed by an authorized representative of the bidder. A fully completed statement shall be deemed to be incorporated by reference into all project bid specifications and contract documents with any bidder on a public improvement. Failure to provide the statement with the bid may result in the bid being deemed nonresponsive. This may result in the bid being rejected by the public body.

**156.2(2) Determining residency status.**

*a.* For purposes of the Act, a person or entity is a resident bidder if the person or entity:

- (1) Is authorized to transact business in Iowa; and
- (2) Has had one or more places of business in Iowa at which it is conducting or has conducted business in this state for at least three years immediately prior to the date of the first advertisement for the public improvement.

*b.* If the person or entity is a resident of a state or foreign country that has a more stringent definition than is set forth in paragraph 156.2(2)“*a*” for determining whether a person or entity in that state or country is a resident bidder, then the more stringent definition applies.

**156.2(3) Determining authorization to transact business.** A person or entity is authorized to transact business in the state if one or more of the following accurately describes the person or entity:

*a.* In the case of a sole proprietorship, the sole proprietor is an Iowa resident for Iowa income tax purposes;

*b.* In the case of a general partnership or joint venture, more than 50 percent of the general partners or joint venture parties are residents of Iowa for Iowa income tax purposes;

*c.* In the case of a limited liability partnership which has filed a statement of qualification in this state, the statement has not been canceled;

*d.* In the case of a limited liability partnership whose statement of qualification is filed in a state other than Iowa, the limited liability partnership has filed a statement of foreign qualification in Iowa and a statement of cancellation has not been filed pursuant to Iowa Code section 486A.105(4);

*e.* In the case of a limited partnership or limited liability limited partnership whose certificate of limited partnership is filed in this state, the limited partnership or limited liability limited partnership has not filed a statement of termination;

*f.* In the case of a limited partnership or a limited liability limited partnership whose certificate of limited partnership is filed in a state other than Iowa, the limited partnership or limited liability limited partnership has received notification from the Iowa secretary of state that the application for certificate of authority has been approved and no notice of cancellation has been filed by the limited partnership or the limited liability limited partnership;

*g.* In the case of a limited liability company whose certificate of organization is filed in this state, the limited liability company has not filed a statement of termination;

*h.* In the case of a limited liability company whose certificate of organization is filed in a state other than Iowa, the limited liability company has received a certificate of authority to transact business in this state and the certificate has not been revoked or canceled;

*i.* In the case of a corporation whose articles of incorporation are filed in this state, the corporation (1) has paid all fees required by Iowa Code chapter 490, (2) has filed its most recent biennial report, and (3) has not filed articles of dissolution;

*j.* In the case of a corporation whose articles of incorporation are filed in a state other than Iowa, the corporation (1) has received a certificate of authority from the Iowa secretary of state, (2) has filed its most recent biennial report with the secretary of state, and (3) has neither received a certificate of withdrawal from the secretary of state nor had its authority revoked; or

*k.* The person or entity is registered with the Iowa division of labor as a construction contractor pursuant to Iowa Code chapter 91C.

**156.2(4) Determining if bidder has conducted business in state.** In order to determine if a bidder has a place of business for transacting business within Iowa at which it is conducting and has conducted business for at least three years prior to the date of the first advertisement of the public improvement, the bidder shall meet the following criteria for the three-year period prior to the first advertisement for the public improvement:

*a.* Continuously maintained a place of business for transacting business in Iowa that is suitable for more than receiving mail, telephone calls, and e-mails; and

b. Conducted business in the state for each of those three years and filed an Iowa income tax return, if applicable, made payments to the Iowa unemployment insurance fund, if applicable, and maintained an Iowa workers' compensation policy, if applicable, in effect for each of those three years.  
[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.3(73A) Application of preference.** When awarding a contract for a public improvement to the lowest responsible bidder, the public body shall allow a preference to a resident bidder as against a nonresident bidder that is equal to any preference given or required by the home state or foreign country in which the nonresident bidder is a resident without regard to whether such preferences are actually enforced by the applicable regulatory body in each state. If the bidder is a subsidiary of a parent that would be a nonresident bidder if such parent were to bid on the public improvement in its own name, then the public body shall allow a preference as against such bidder that is equal to the preference given or required by the home state or foreign country of the bidder's parent. In the instance of a labor force preference, a public body shall apply the same resident labor force preference to a public improvement in this state as would be required in the construction of a public improvement by the home state or foreign country of the nonresident bidder, or the parent of a resident bidder if the parent would qualify as a nonresident bidder if such parent were to bid on the public improvement in its own name.

A preference shall not be applied to a subcontractor unless the home state or foreign country of the nonresident bidder to whom the contract was awarded would apply a preference to the subcontractor.

Specific methods of calculating and applying a preference shall mirror those that apply in the home state or foreign country of the nonresident bidder to whom the contract was awarded. In the event that the specific method used by the nonresident bidder's home state or foreign country cannot be determined, the calculation for a labor force preference shall include only the labor force working on the public improvement in Iowa on a regular basis calculated by pay period.  
[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.4(73A) Complaints regarding alleged violations of the Act.**

**156.4(1) Complaints.** Any person with information regarding a violation of the Act may submit a written complaint to the commissioner. Any complaint must provide the information required pursuant to subrule 156.4(2) or as much of such information as is reasonably practicable under the circumstances. The completed written complaint form shall be submitted to the commissioner at Labor Services Division, 1000 East Grand Avenue, Des Moines, Iowa 50319.

**156.4(2) Written complaint form.** The commissioner shall prepare a written complaint form that a person with information regarding a potential violation of the Act may submit pursuant to subrule 156.4(1). The written complaint form shall request the following information: the name, address, telephone number, and e-mail address of the complainant; the name of the bidder that is believed to have violated the Act; a description of any relationships between the complainant and the bidder; an identification of the public body to which the bidder submitted a bid; the home state or foreign country of the bidder; a description of the goods and services provided under the bid; and such additional information as requested by the commissioner.

**156.4(3) Availability of written complaint form.** The written complaint form shall be available in all division offices and on the department of workforce development's Internet Web site.  
[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.5(73A) Nonresident bidder record-keeping requirements.** While participating in a public improvement, a nonresident bidder from a home state or foreign country with a resident labor force preference shall make and keep, for a period of not less than three years, accurate records of all workers employed by the contractor or subcontractor on the public improvement. The records shall include each worker's name, address, telephone number if available, social security number, trade classification, and starting and ending date of employment.  
[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.6(73A) Investigations; determination of civil penalty.** The commissioner or an authorized designee shall cause an investigation to be made into charges of violations of the Act, including allegations set forth in a written complaint.

**156.6(1) Investigative powers.** The commissioner or the authorized designee shall have the following powers:

*a. Hearings.* The commissioner may hold hearings and investigate charges of violations of the Act.

*b. Entry into place of employment.* The commissioner may, consistent with due process of law, enter any place of employment to inspect records concerning labor force residency, to question an employer or employee, and to investigate those facts, conditions, or matters as are deemed appropriate in determining whether any person has violated the provisions of the Act. The commissioner shall only make an entry into a place of employment in response to a written complaint.

*c. Residency of workers.* The commissioner may investigate and ascertain the residency of a worker engaged in any public improvement in this state.

*d. Oaths; depositions; subpoenas.* The commissioner may administer oaths, take or cause to be taken deposition of witnesses, and require by subpoena the attendance and testimony of witnesses and the production of all books, registers, payrolls, and other evidence relevant to a matter under investigation or hearing.

*e. Employment of personnel.* The commissioner may employ qualified personnel as are necessary for the enforcement of Iowa Code section 73A.21. The personnel shall be employed pursuant to the merit system provisions of Iowa Code chapter 8A, subchapter IV.

*f. Request for records.* The commissioner shall require a contractor or subcontractor to file, within 10 days of receipt of a request, any records enumerated in rule 875—156.5(73A). If the contractor or subcontractor fails to provide the requested records within 10 days, the commissioner may direct, within 15 days after the end of the 10-day period, that the fiscal or financial office charged with the custody and disbursement of funds of the public body that contracted for construction of the public improvement or undertook the public improvement, to withhold immediately from payment to the contractor or subcontractor up to 25 percent of the amount to be paid to the contractor or subcontractor under the terms of the contract or written instrument under which the public improvement is being performed. The amount withheld shall be immediately released upon receipt by the public body of a notice from the commissioner indicating that the request for records as required by this paragraph has been satisfied.

**156.6(2) Division determination.** Upon conclusion of an investigation, the commissioner or an authorized designee shall issue a written determination to the party that was the subject of the investigation. The determination shall indicate whether or not the division finds a violation of the Act by the party. If the determination indicates that the party engaged in a violation of the Act, the determination shall also indicate the remedies the division intends to pursue as a result of the violation.

**156.6(3) Informal conference.** A party seeking review of the division's determination pursuant to this rule may file a written request for an informal conference. The request must be received by the division within 15 days after the date of issuance of the division's determination. During the conference, the party seeking review may present written or oral information and arguments as to why the division's determination should be amended or vacated. The division shall consider the information and arguments presented and issue a written decision advising all parties of the outcome of the informal conference.

[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.7(73A) Remedies.** Following the conclusion of the informal conference, or following the expiration of the time in which a party may file a written request for an informal conference, the division may pursue the following remedies.

**156.7(1) Injunctive relief.** If the division determines that a violation of the Act has occurred, the division may sue for injunctive relief against the awarding of a contract, the undertaking of a public improvement, or the continuation of a public improvement.

**156.7(2) *Civil penalty.*** Any person or entity that violates the provisions of this chapter is subject to a civil penalty in an amount not to exceed \$1,000 for each violation found in a first investigation by the division, not to exceed \$5,000 for each violation found in a second investigation by the division, and not to exceed \$15,000 for a third or subsequent violation found in any subsequent investigation by the division. Each violation of this chapter for each worker and for each day the violation continues constitutes a separate and distinct violation. In determining the amount of the penalty, the division shall consider the appropriateness of the penalty to the person or entity charged, upon determination of the gravity of the violation(s). The collection of these penalties shall be enforced in a civil action brought by the attorney general on behalf of the division.

[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.8(73A) Compliance with federal law.** If it is determined that application of this chapter and the Act may cause denial of federal funds which would otherwise be available for a public improvement, or would otherwise be inconsistent with requirements of any federal law or regulation, the application of this chapter shall be suspended to the extent necessary to prevent denial of the funds or to eliminate the inconsistency with federal requirements.

[ARC 1271C, IAB 1/8/14, effective 2/12/14]

**875—156.9(73A) Severability.** If any rule under this chapter, any portion of a rule under this chapter, or the applicability of any rule under this chapter to any person or circumstance is held invalid by a court, the remainder of these rules or the rules' applicability to other persons or circumstances shall not be affected.

[ARC 1271C, IAB 1/8/14, effective 2/12/14]

These rules are intended to implement Iowa Code section 73A.21.

[Filed ARC 1271C (Notice ARC 1160C, IAB 10/30/13), IAB 1/8/14, effective 2/12/14]



CHAPTERS 157 to 159  
Reserved